

297011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/transit permit. Then please remove from this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

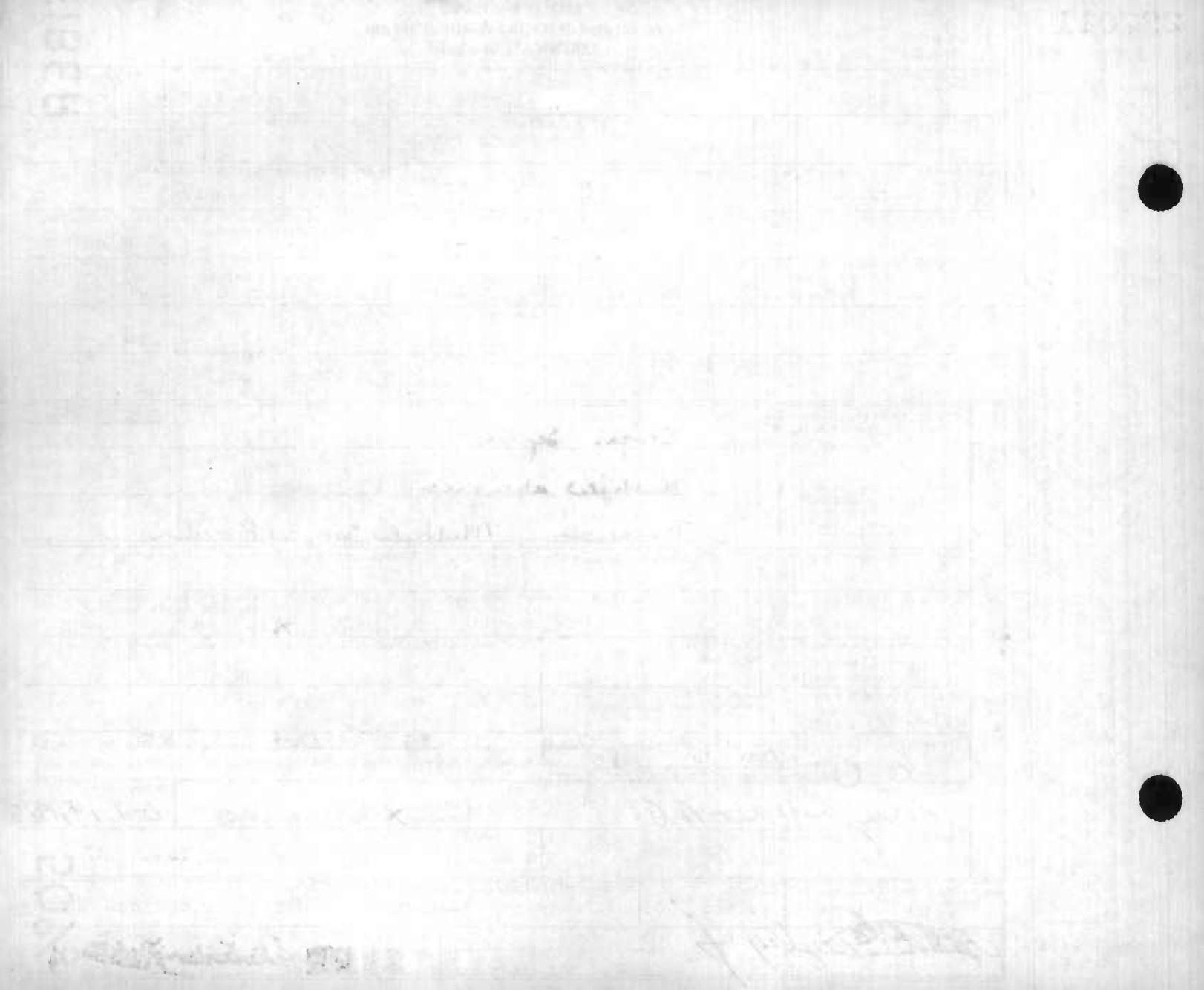
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 8 / 1 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)	FIRST HUBERT	MIDDLE DEE	LAST BAILEY	2a. DATE OF DEATH OCT. 12, 1985	MONTH YEAR	DAY 1985	2b. HOUR 5:45 a.m.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR NOV. 26, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE COUNTRY West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County MD.			
10. CITY OR TOWN OF DEATH Thurmont	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 39 E. Moser Rd., Thurmont, Md. 21788 (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Thurmont	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 39 E. Moser Rd./21788			
14. FATHER'S NAME FIRST John	MIDDLE W.	LAST Bailey	15. MOTHER'S MAIDEN NAME FIRST Ellen	MIDDLE NMI	LAST Shaffer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None	17. INFORMANT Madlyn Bailey	ADDRESS 39 E. Moser Rd. Thurmont Maryland 21788		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Staph. Sepsis</i>							
DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Multifocal abscesses.</i>							
DOUE TO, OR AS A CONSEQUENCE OF (c) <i>Tracheostomy / Multiple Surgical Procedure.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>85</u> , to <u>Oct.</u> , 19 <u>85</u> , that (II) (we) last saw the deceased alive on <u>Oct 10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, <input type="checkbox"/> did not)							
22b. SIGNATURE <i>Amy Jones MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Oct. 14, 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Amy Jones, M.D.	22e. ADDRESS 4 W. 7th St. Frederick, Maryland 21701						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Oct. 15, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens	23d. LOCATION CITY OR TOWN Frederick	23e. COUNTY Frederick	23f. STATE Md.		
24. FUNERAL DIRECTOR Robert E. Dailey & Son				25a. ADDRESS 615 E. Main St. Thurmont, Md. 21788	25b. DATE REC'D. BY REGISTRAR OCT 21 1985	25c. REGISTRAR'S SIGNATURE <i>J. L. Dailey Jr.</i>	



312006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

filled in by the physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial permit. Then please remove this page from the certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the physician and the burial permit, then please remove this page from the certificate.

with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If Item 21 is checked or Item 18 shows any injury as either remote or terminal, the medical examiner must be notified.

MEDICAL CERTIFICATION

510
1 - STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 2871

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Richard Vance Baldwin						10 29 85				4:45 PM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
M		W	MONTH	9	DAY	32	53	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Illinois		U.S.A.							Frederick MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital Mech. Engineer Corp.										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			14. STREET ADDRESS, ZIP CODE						
Maryland		Frederick	Adamstown			Adamstown, Md. 21710						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		Richard	M.	Baldwin			Nancy		Vance			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		328-26-3535			Mildred Baldwin Adamstown, Md.							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Diabetes Mellitus.</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 10/29/85 to 10/29/85, that (I) (we) last saw the deceased alive on 10/29/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>P. Sherrin M.D.</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/29/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Philip Chaspin MD</i>		22e. ADDRESS 814 Toll House Ave Frederick, Md. 21701										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 11-01-85		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION Smithsburg Washington Md.						
Cremation												
24. FUNERAL DIRECTOR NAME		G. Douglas Stauffer			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>G. Stauffer, Jr.</i>					
		1621 Opossumtown Pk. Frederick, Md. 21701			04 1985							

2005.3.16



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the bond of honor permit. Then please remove carbon papers. Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner may be called.

303060

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 12

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Carla Ann Barnhouse						10/23/85				10:55 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
Female		White		April 3, 1930		55							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Yarrowsburg, Md.		U. S. A.				Frederick							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Memorial Hospital		Housewife		Own Home							
13a. STATE Maryland						13b. COUNTY Washington		13c. CITY OR TOWN Gapland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21736	
FATHER'S NAME FIRST Unknown		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Oneida		MIDDLE A.		LAST Sigler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IS NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		220-28-8543		Mr. Henry A. Barnhouse, Gapland, Md. 21736									
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoxic Encephalitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Small Cell Carcinoma</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (we) attended the deceased from <u>10/22</u> , 19 <u>81</u> , to <u>10/23</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>10/22</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>Michael Behre</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/23/85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Behre</u>		22e. ADDRESS <u>Middleton, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10-27-85		23c. NAME OF CEMETERY OR CREMATORIUM Brownsville Hgts. Cem.		23d. LOCATION CITY OR TOWN Brownsville, Wash. Co., Md.							
24. FUNERAL DIRECTOR <u>John H. Bast, Jr.</u>		ADDRESS <u>Boonsboro, Md. 21713</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 28 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John H. Bast, Jr.</u>							

BUDDY

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RECEIVED FROM THE GOVERNMENT OF CANADA

GOVERNMENT OF CANADA
DEPARTMENT OF NATIONAL DEFENCE

DEFENCE INFORMATION COMMISSION

DEFENCE INFORMATION COMMISSION

DEFENCE INFORMATION COMMISSION

DEFENCE INFORMATION COMMISSION

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1026-00-000

REF ID:

DEFENCE INFORMATION COMMISSION

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DEFENCE INFORMATION COMMISSION

305107

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 28713					
1- FOR STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
William Andrew BOONE, JR.												10 22 1985	M				
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 yrs.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10 22 1985		MONTH	DAY	YEAR	2d. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County											
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 727 North Market Street									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed Investigator			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 727 North Market St., 21701								
14. FATHER'S NAME FIRST William MIDDLE Andrew LAST Boone, Sr.			15. MOTHER'S MAIDEN NAME FIRST Annabelle MIDDLE Bennett LAST														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> Yes			16b. SOCIAL SECURITY NO. 1944-1946			17. INFORMANT Mrs. Evelyn Bennett 727 North Market St., Frederick, Md. 21701											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Robert J. Thomas MD		TITLE (SPECIFY) M.D. Deputy										MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 812 Toll House Ave., Frederick, Md.									DATE SIGNED 10/23/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 25, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick, Md.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Smith, Keeney & Basford Funeral Home ADDRESS 106 East Church St., Frederick, Md. 21701			25a. DATE REC'D. BY REGISTRAR Oct. 29, 1985									25b. REGISTRAR'S SIGNATURE John L. Pendall					
BP																	
DHMH - 17 (VR A15 ME (5))																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Please remove carbon paper. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked "yes" on other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 28 / 14			
1 - STATE REGISTRAR			REG. NO.										
1a. RELEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Laura Highley Bourne					10/13/85					2150			
Female		B			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MONTH	DAY	YEARS	MONTHS	DAYS	HOURS	MIN.		
VA.		U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		88				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick		Frederick-Memorial Hosp. Steam Tree			Frederick			MD.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		ZIP CODE			
Md		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		812 W. South - 21701					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		ADDRESS		ADDRESS		LAST			
Bernard		J.	Holland	Rosetta Williams		Frederick-Md 21701							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		218-50-5295			Blanche Tyree-7055 Basswood								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b1, and c1) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (he) (this hospital) attended the deceased from 10/13/85, 19, to 10/13/85, 19, that (he) (we) last saw the deceased alive on 10/13/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, (he) (we) did not)													
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
Austin A. Pearce Jr.								10/14/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Austin A. Pearce Jr.		804 Tollhouse Ave Fred. Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY STATE COUNTY		25a. DATE REC'D. BY REGISTRAR					
CREMATION		Oct 15, 1985		DAVIS F. Home		Smithsburg Wash. Md		OCT 16 1985					
24. FUNERAL DIRECTOR NAME		25b. REGISTRAR'S SIGNATURE											
C.E. Hicks III Annapolis - Md.													

Notes

291006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6528715

1 - STATE
REGISTRAR

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d HOUR		
Harold M. Brown Sr.						10-13-85				a.m. 11:50		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 18 yrs		
Male		Negro		MONTH	DAY	YEAR	53	YRS		IF UNDER 21 HRS		
6. MONTH		7. DAY		8. YEAR			MONTHS		DAYS		HOURS	
6. Male		7. Negro		8. 6 5 32			9. Months		Days		Hours	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Frederick		U.S.A.					Frederick					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick memorial Hospital			Self-Employed			Contractor				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE Maryland						
13b. COUNTY Frederick						13c. CITY OR TOWN Frederick						
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE 21701 3547 Hopeland Rd. Fred. Md.						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Lloyd		D.		Brown		Marie		E.		Lee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. Yes Korean 220-26-0455		17. INFORMANT Frederick		ADDRESS Md. 21701 Delores A. Brown 3547 Hopeland Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3yrs</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Lung</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>cause unknown</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that <input checked="" type="checkbox"/> (I) (we) attended the deceased from <u>13 Oct 1985</u> to <u>13 Oct 1985</u> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>13 Oct 1985</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) did not view the body after death.								COUNTY				
22b. SIGNATURE		22c. DEGREE			22d. DATE SIGNED							
Morris Wilkinson		MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			13 Oct 1985				
22e. ADDRESS												
22f. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		10-17-85		Hopehill cemetery			Frederick		Frederick		Md.	
24. FUNERAL DIRECTOR NAME		G. Douglas Stauffer ADDRESS 1621 Opossumtown Pike, Fred. Md. 21701			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
					OCT 16 1985							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death. ³

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

303835



2-28-1948
Dear Mr. and Mrs. [unclear]
I am enclosing a copy of the
Newspaper clipping which
you wanted. I hope you will find it
useful.
Yours very truly,
John [unclear]

291032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FA. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE EFILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MAILED			MONTH	DAY	YEAR	2b. HOUR		
MARY			ELIZABETH	BUFFINGTON		10/14/85	10	14	85			9:45 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE IN YEARS		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		
FEMALE		WHITE		YEAR	12/04/96	LAST BIRTHDAY	12/04/96	YEARS	88	HOURS	88	Oct 14 1985	9:45 AM	
7b. BIRTHPLACE (STATE OR CITY)		7c. CITIZEN OF WHAT COUNTRY?				8. MARRIED		NEVER MARRIED		WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		U.S.A.				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		FREDERICK		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION									12a. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY)		
FREDERICK			FREDERICK MEMORIAL HOSPITAL									SEAMSTRESS		
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			MD STATE			CITY OR TOWN			NO			13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
FREDERICK			KEYMAR			NO						<input type="checkbox"/> YES	<input type="checkbox"/> NO	11736 GOOD INTENT RD. 21757
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME						LAST		
ULYSSES G. DAYHOFF						FANNIE ELIZABETH LEAKINS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (ES. NO. OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			216-22-9893			THORNTON E. SMITH			11736 GOOD INTENT RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Disease</i> . DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John G. Ball</i>			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED <i>Oct 14 1985</i>					
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL <i>Robert J. Thomas, M.D.</i>			ADDRESS			812 Toll House Ave. Frederick, Md. 21701								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/16/85			23c. NAME OF CEMETERY OR CREMATORIUM MT. VIEW CEMETERY			24a. UNION BRIDGE, GERRRROLL STATE MT. VIEW CEMETERY MD					
24b. DATE REC'D. BY REGISTRAR OCT 16 1985			25b. REGISTRAR'S SIGNATURE <i>Wilson Handee</i>											
BP			ADDRESS UNION BRIDGE, MD											
DHMH - 17 (VR A15 ME (5))														
20M 4/B2														

3341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy of Part I, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial; cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event the medical examiner must be notified at once.

296165

852817

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<u>Mary Anna Burkett</u>						<u>Oct 17</u>	<u>1985</u>			<u>1025</u>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<u>Female</u>		<u>White</u>		MONTH	DAY	YEAR	<u>65</u>	YRS.	MONTHS	DAYS	IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
<u>Maryland</u>		<u>U.S.A.</u>				<u>Frederick</u>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<u>Frederick</u>		<u>Frederick Memorial Hosp.</u>		<u>Housekeeping</u>			<u>Hospital</u>				
13a STATE <u>Md.</u>		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		21701	
				<u>Frederick</u>				<u>123 W. Church St. FRed. Md.</u>			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
<u>Howard</u>		<u>F.</u>	<u>Drury</u>	<u>Rhoda Belle Murtz</u>		<u>214-09-9739</u>		<u>Austin F. Drury Frederick Md.</u>		<u>21701</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost (c) _____											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Shock, Renal Failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>20-17</u> , 19 <u>85</u> , to <u>10-17</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>10-17</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Kusay Barakat</u>		22c. DEGREE				22d. DATE SIGNED					
22e. ADDRESS <u>385 Park Avenue, Frederick MD 21701</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-21-85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Olive</u>		23d. LOCATION CITY OR TOWN <u>Frederick</u>		COUNTY <u>Frederick</u>		STATE <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>G. Douglas Stauffer</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 24 1985</u>				25b. REGISTRAR'S SIGNATURE <u>J. Johnson, Reg.</u>					

contents



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this document be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please send completed papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, embalming or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

311138

Film G609 item 15

1 - STATE 11/29/85 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 8 / 1 1 0

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Arlene	Dora	BURNETTE	10 27 85				22 59 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		White		MONTH	2	DAY	2	YEAR	83	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		U.S.A.					Frederick			MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Memorial Hospital		Housewife			Home				
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
W. Virginia Fayette		Oak Hill					P.O. Box 262 Oak Hill W. Va.				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS				
Lewis		G.	Lilly	Louesta			Elizabeth Louise Emeline			Lilly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		233-96-9912		Gene Burnette, Thurmont Md.			2 days				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c)											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>coronary atherosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>hypertension</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
<u>gastroesophageal reflux disease</u> <u>renal insufficiency</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (in this hospital) attended the deceased from <u>10-21</u> 19 <u>85</u> , to <u>10-27</u> 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-27</u> 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we did) (did not) view the body after death.											
22b. SIGNATURE <u>S. Khan</u> <u>MD</u>				22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>10-27-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. Khan</u>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial		10-31-85		Blue Ridge Ceme			Prosperity			Raleigh	W. Va.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
G. Douglas Stauffer 1621 Opossumtown Pk. Fred. md. 21701		Oct 31 1985									

999999
BP

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1
2
3
4



ROCK BOTTOM BEER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be retained for use as the burial/transit permit. Then please return certificate papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must determine cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 2 3 / 1 9							
1 - STATE REGISTRAR Charles Kemp Cashour, Jr.												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Charles Kemp Cashour Jr.						October 18, 1985						7:00 A.M.							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		Aug. 23, 1933			52			MONTHS	DAYS	HOURS	MIN.						
YRS.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Frederick County, MD.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Frederick		Frederick Memorial Hospital		Policeman			City Government												
13a. STATE Maryland												13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 331 Braddock Ave., 21701	
14. FATHER'S NAME FIRST MIDDLE LAST												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles Kemp Cashour, Sr.												Mary Gertrude Hamilton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Yes		1954-1956		216-30-2978			Mrs. Mary F. Cashour, Frederick, Md. 21701												
19. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) Cardiac arrhythmia							
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>several years</u> 19 <u>85</u> to <u>10/18/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>several months</u> 19 <u>ago</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Austin Pearre		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10/18/85												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		804 Toll House Ave., Frederick, Md. 21701															
Dr. Austin Pearre, Jr., M.D.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE												
Burial		Oct 21, 1985		Mount Olivet Cemetery			Frederick, Frederick, Md.												
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701							25a. DATE REC'D. BY REGISTRAR OCT 22 1985			25b. REGISTRAR'S SIGNATURE John K. Johnson									

STOLES

2005 15 minutes

At 100% speed

100%, 80%

actual duration

duration

duration

duration

duration

duration

actual

duration



duration

duration

duration

duration

duration

duration

duration

duration

duration

303058

8528720

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>BILLY</i>	MIDDLE <i>JACK</i>	LAST <i>CLARK</i>	2a. DATE OF DEATH MONTH <i>April</i>	DAY <i>18</i>	YEAR <i>1926</i>	2b. HOUR <i>0315 M</i>		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH <i>April</i>		DAY <i>18</i>	YEAR <i>1926</i>	6. AGE (IN YEARS LAST BIRTHDAY) 59	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick, MD.					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.				12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4332A Basford Road/21701			
14. FATHER'S NAME FIRST George		MIDDLE R.	LAST Clark	15. MOTHER'S MAIDEN NAME FIRST Thehma		MIDDLE 	LAST Browning				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT Mrs. Mamie R. Clark		ADDRESS 4332A Basford Road Frederick, Md. 21701			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b and c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Black lung</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>now</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>1011</i>		21f. LOCATION STREET <i>1011</i>			CITY OR TOWN <i>10126</i>	COUNTY <i>10126</i>	STATE <i>10126</i>		
22a. I certify that (I) (the hospital) attended the deceased from <i>10/11</i> , 19 <i>81</i> , to <i>10/26</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>10/25</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Lloyd Halverson</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>10/16/85</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lloyd Halverson</i>		22g. ADDRESS <i>1475 Tangier Blvd</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial		23b. DATE 10-29-85		23c. NAME OF CEMETERY OR CREAMATORY Forest Lawn Cemetery		23d. LOCATION CITY OR TOWN Peck's Mill, Logan, W.Va.					
24. FUNERAL DIRECTOR <i>R.E. Dailey & Son, PA</i>		25a. ADDRESS <i>1201 N. Market Street</i>		25b. DATE REC'D. BY REGISTRAR <i>Oct 28 1985</i>		25c. REGISTRAR'S SIGNATURE <i>R.E. Dailey & Son, PA</i>					

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

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БОХДОН МЫРЗА

296017

852872

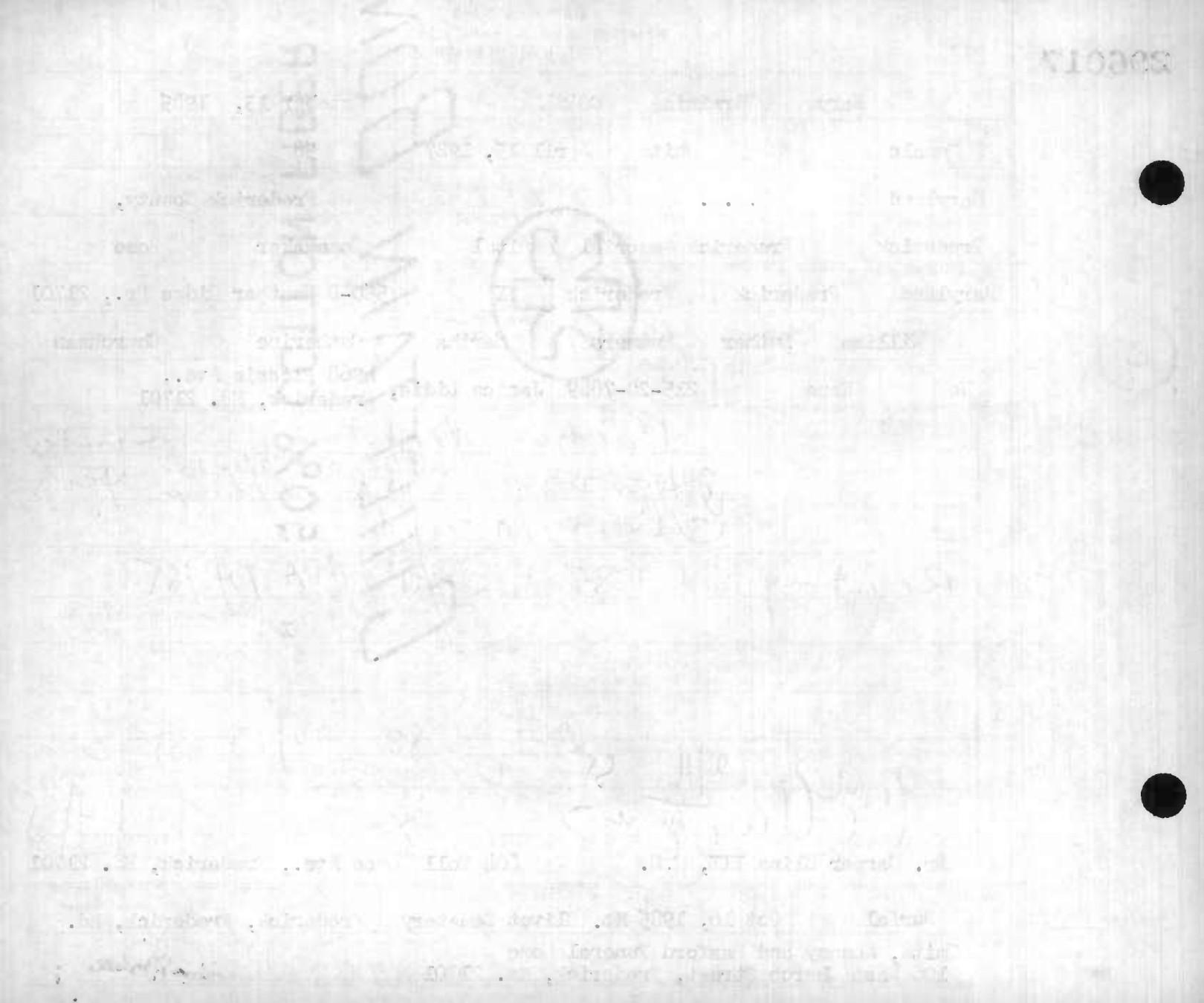
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR							
			Mary	Virginia	COVELL	October 13, 1985											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR								
Female		White		Month April 15, 1927		58			IF UNDER 24 HRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		6. AGE (IN YEARS LAST BIRTHDAY)			MONTHS DAYS HOURS MIN.								
Maryland		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		58			YRS								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Frederick		Frederick Memorial Hospital				Homemaker			Home								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		15. STREET ADDRESS / ZIP CODE 550-B Heather Ridge Dr., 21701	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. None 215-20-7849			17. INFORMANT Janice Lidie, Frederick, Md. 21701			ADDRESS 4968 Flossie Ave., Frederick, Md. 21701					
18. CAUSE OF DEATH (Enter only one cause per line for items (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))						DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxemia from pulmonary disease (c) Coronary Artery disease			Cardiac Arrest			Approximate Interval Between Onset and Death minutes					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first						DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxemia from pulmonary disease (c) Coronary Artery disease			Chronic Obstructive years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Recent myocardial infarction 9/51 & CVA 10/6/85																	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 10/11/85 to 10/13/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						22b. DEGREE			22c. DATE SIGNED 10/14/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Casper Cline III, M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE Oct 16, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick, Frederick, Md.							
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701						25a. DATE REC'D. BY REGISTRAR 10/17/85		25b. REGISTRAR'S SIGNATURE G. J. Cline, M.D.									

BP _____



288011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copy of page 2 and 3 and attach to burial/transit permit. This certificate should be detached for use on the burial/transit permit. Then please remove carbon copy of page 2 and 3 and attach to burial/transit permit. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, this medical certification must be attached to the death certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8528722				
										REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Sister Emmelia Craven						Oct. 9, 1985			12:45aM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			White			Aug. 10, 1896			89 YRS.					
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Ireland			U.S.A.						Frederick					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Emmitsburg			Villa St. Michael, Emmitsburg, Md.			Child Care			lgtrs. of Charit			21727		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Frederick		Emmitsburg					333 S. Seton Avenue				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Patrick Craven			Ellen Riley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			219-54-0702 T			Sr. Josephine-Villa St. Michael, Emmitsburg								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerosis, cardiovascular disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
MEDICAL CERTIFICATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19a. DATE OF OPERATION						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I this hospital) attended the deceased from 1977 19 to 10/17/85 19, that (I was lost now the deceased alive on 10/17/85 19, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (I did not) view the body after death.														
22b. SIGNATURE <i>George L. Morningstar, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9 October 85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			S. Seton Ave. Emmitsburg, MD 21727								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 11 Oct 85			23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's			23d. LOCATION CITY OR TOWN Emmitsburg			COUNTY Frederick, MD		
24. FUNERAL DIRECTOR NAME Skiles Funeral Home, Emmitsburg, MD 21727			ADDRESS			25a. DATE REC'D. BY REGISTRAR Oct 14 1985			25b. REGISTRAR'S SIGNATURE <i>John L. Skiles</i>					

51006



296149

8528/23

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>ALDINE</i>	MIDDLE <i>H.</i>	LAST <i>DEAN</i>	2a. DATE OF DEATH MONTH <i>Dec. 11, 1989</i>	MONTH <i>DAY</i>	DAY	YEAR	2b. HOUR <i>1:20 PM</i>		
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH <i>Dec. 11, 1909</i>			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.				
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7921 Runnymede Drive, 21701				
14. FATHER'S NAME FIRST Benjamin		MIDDLE A.	LAST Card	15. MOTHER'S MAIDEN NAME FIRST Jenny		MIDDLE	LAST Chumley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS mrs. Carol Vachon, 7921 Runnymede Drive Frederick, Md. 21701							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))		<i>Congestive heart failure</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <i>Artherosclerotic Cardio-vascular disease</i>										
(c)		DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
SEVERE chronic obstructive pulmonary disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20e. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1983</i> , 19 <i>84</i> , to <i>OCTOBER 19 85</i> , that (we) last saw the deceased alive on <i>16 OCTOBER 1985</i> , and that in (my) <i>poor</i> opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>George I. Smith Jr., M.D.</i>		DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>16 Oct. 85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George I. Smith, Jr., M.D.		22e. ADDRESS 804 Toll House Ave., Frederick, Md. 21701										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 18, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick, Frederick, Maryland		COUNTY	STATE		
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701					25a. DATE REC'D. BY REGISTRAR <i>21 OCT 1985</i>			25b. REGISTRAR'S SIGNATURE <i>John K. Deppelle</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then attach to this certificate page 3 should be filled within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified.

CLAPPS



305145

85 23 / 24

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			Virdia	A.	DUNN	October	24,	1985		8:10 am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		MONTH Oct.	DAY 1	YEAR 1902	83	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		U.S.A.						Frederick County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Frederick		Meridian Nursing Center		Teacher		Education						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE												
Maryland		13b. COUNTY	Frederick	13c. CITY OR TOWN	Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		220 N. Market Street/ 21701			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Thomas		Austin	Allender	Lottie			Raines					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		220 North Market Street, Frederick, Maryland 21701						
No		None		220-10-5498								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>ASHD</i> <i>Senility</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10-1-</u> 19 <u>85</u> , to <u>10-24-</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10-1-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>Rex Martin</i>		22c. DEGREE <i>MD</i>				22d. DATE SIGNED <i>10-24-85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS Rex Martin, MD 220 N. Market St., Frederick, Md. 21701										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Oct 26, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick, Frederick, Maryland						
24. FUNERAL DIRECTOR <i>Frank Robison</i> Smith, Keeney & Bass Funeral Home 106 East Church Street, Frederick, Md. 21701						25a. DATE REC'D. BY REGISTRAR <i>OCT 28 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julie Seiden-Pordell</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as a burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 1b shows any injury, or other traumatic event, the medical examiner will be notified.

24308

295115

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 1 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3, WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28 / 23

REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR				
			Larry	Albert	Earp	10-14	19	85	M					
3	SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 6:31 p.m.			
	Male	White	Nov. 11, 1949	35 yrs.			10-14	19	85					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			American						Frederick County, MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial Hospital			Cashier-Super.			Montg. Co. Gov't.					
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Mt. Airy			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 158 Wicomico Court		
14. FATHER'S NAME FIRST Albert			MIDDLE Earp			15. MOTHER'S MAIDEN NAME Connie			16. ADDRESS			LAST Shipley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes			212-54-2162			Tina Earp Item 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) Cranio-cerebral Trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX:XX MONTH DAY YEAR 5:35 P.M. 10-14 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) driver of auto struck by truck								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET Rt. 75 near Windsor Mill Rd., Frederick,			CITY OR TOWN			COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
EXAMINER'S NAME (TYPE OR PRINT)			Dennis F. Smyth, M.D.			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 10-15-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10/17/85			23c. NAME OF CEMETERY OR CREMATORIUM Damascus Cemetery			23d. LOCATION CITY OR TOWN Damascus			COUNTY STATE Montgomery, Md.		
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 18 1985			25b. REGISTRAR'S SIGNATURE Gina Sundeen					
BP			DHMH - 17 (VR A15 ME (5))											

Series

Type

File number Nov. 11, 1946 32

X

Verdict

Motivating

Chapter-number Chap. 10

51A71

x 158 Mexican Court

Motivating M.F. Vito

Motivating

Topic

Course

Lab

Type

515-54-5162 This was item 13

Yes

Serial 10/11/46 Damages George W.M.

Office of the Commonwealth, Commonwealth of Massachusetts

311147

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28125

1 - FOR
STATE
REGISTRAR

REG. NO.

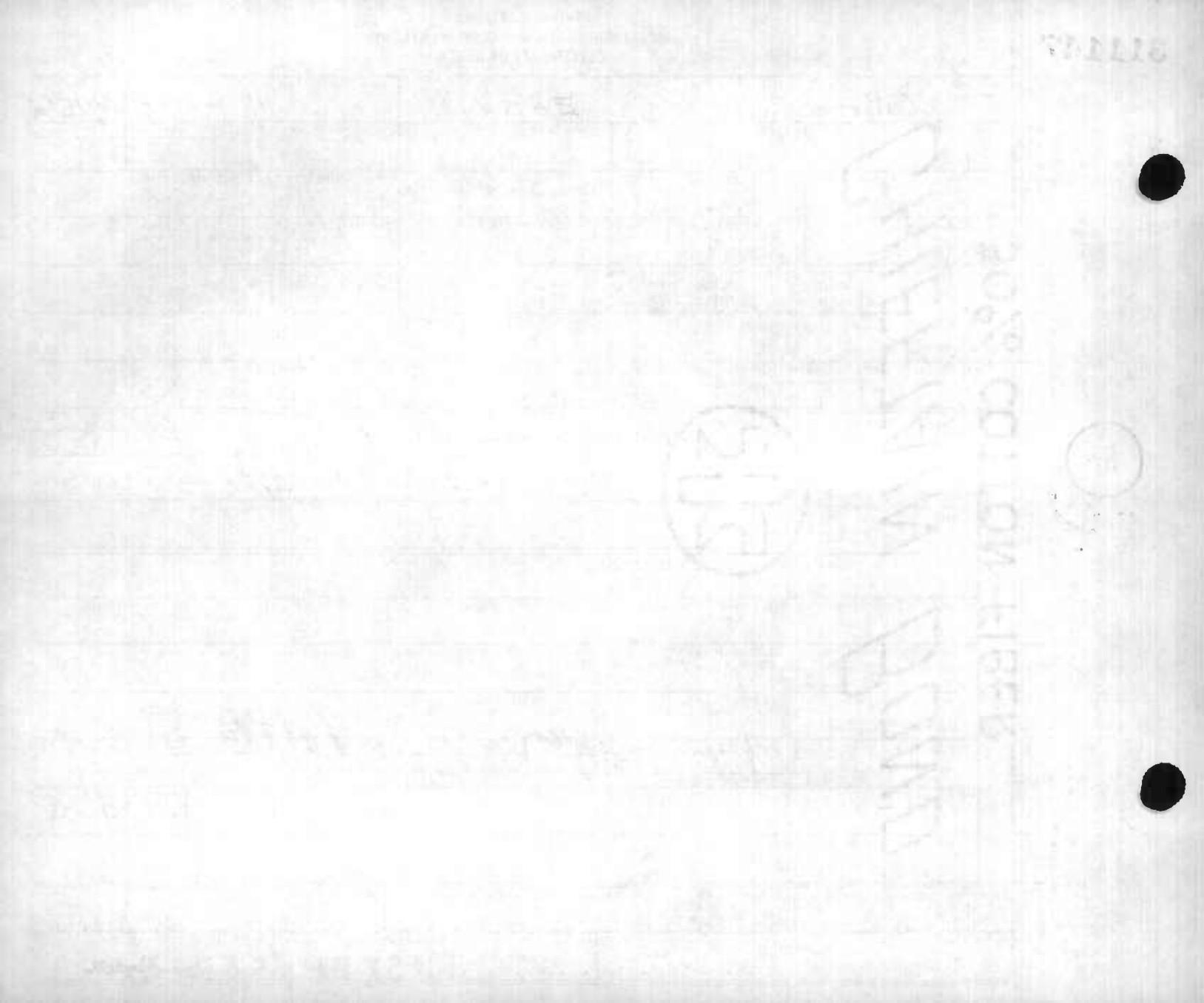
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Catherine Helen</i>					<i>EATON</i>	10	26	85	1205PM		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.	
Female	White	MONTH	DAY	YEAR	74						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland	U.S.A.				Frederick						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Frederick	Frederick Memorial Hospital					Housewife			Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS / ZIP CODE			21701		
Md.	Frederick	Frederick				10602 Bethel Rd. Fred. Md.					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Orvey	W.		McBride	Levona			E.		Fraley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No	214-28-7364			Frank Eaton Frederick Maryland							
18. CAUSE OF DEATH: Enter only ONE cause per line for item 18, Part I, and in PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral artery</i>											APPROPRIATE PARENTHETICAL EXPLANATION OR DECLARATION
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i>											4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) examined the deceased from saw the deceased alive on <i>19/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John Hickey</i> DEGREE											
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS											
T. F. Hickey 516 Trail Ave. Fred. Md. 21701											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIES			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
Burial	10-30-85	Resthaven Mem. Gds			Frederick Fred. Md.						
24. FUNERAL DIRECTOR NAME 1621 Opossumtown Pk. Fred. Md. 21701	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
				OCT 31 1985			John Davidson, R.N.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use in the burial permit. Then please return certificate to me. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

1115



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the funeral home permit. Then please remove carbon papers. Page 2 should be held with 72 hours after death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8528727

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Leona			M.	Eby		10-8-85				5:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR 5-26-1910		75		YEARS MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Frederick					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Thurmont		119 Water St. Thurmont Md.		Housewife		Home					
13. USUAL RESIDENCE (IF NURSING HOME, OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						14. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21788			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
James		Edgar	Miller	Mary		Catherine	Stitley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		219-07-4882		James H. Eby		119 Water St. Thurmont					
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first						<i>Acute myocardial Infarction</i>					
(b)						<i>Hypertension</i>					
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11</u> 19 <u>78</u> to <u>10</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>9/3/85</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) care for the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		21788			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
William F. Harper		100 South Center St. Thurmont Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		10-11-85		Blue Ridge Ceme.		Thurmont		Frederick	Md.		
24. FUNERAL DIRECTOR NAME		G. Douglas Stauffer 1621 Opossumtown Pike Fred. Md. 217		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Johanna K. Miller</i>					
BP _____											
DHMH - 16 60M 7/84 (VRA 15, 4)											

50206

REED HOLLOW STATE PARK



295150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked as Item 21, certify injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8528/28

1. FOR STATE REGISTRAR													
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Frances Ella Eury						Oct. 9, 1985				4:00 A.M.			
3. SEX			4. RACE		S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female			White		May 25, 1901	84 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA					Frederick County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Knoxville			Residence - 1404 Souder Road						Housewife			Homemaker	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			Frederick		Knoxville					1404 Souder Rd. / 21758			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Amos			?	Cannon	Mathha			Elizabeth	Waters				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
No			212-74-3487		Dorothy Cannon - Knoxville, Md. 21758			1404 Souder Rd. -					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADVANCED ALZ HEMER'S DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 10/17/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we did) (did not) view the body after death.			10/30/81			10/9/85							
22b. SIGNATURE <u>Wayne Allgaier</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/9/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne Allgaier, M.D.			22e. ADDRESS 610 - 9th Ave. - Brunswick, Md. 21716										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/11/85		23c. NAME OF CEMETERY OR CREMATORIAL Park Heights Cem.			23d. LOCATION CITY OR TOWN Brunswick, Fred. MD.			23e. COUNTY Brunswick		
24. FUNERAL DIRECTOR NAME John T. Williams Funeral Home			ADDRESS BRUNSWICK, MD.			25a. DATE REC'D. BY REGISTRAR OCT 15 1985			25b. REGISTRAR'S SIGNATURE <u>John T. Williams</u>				

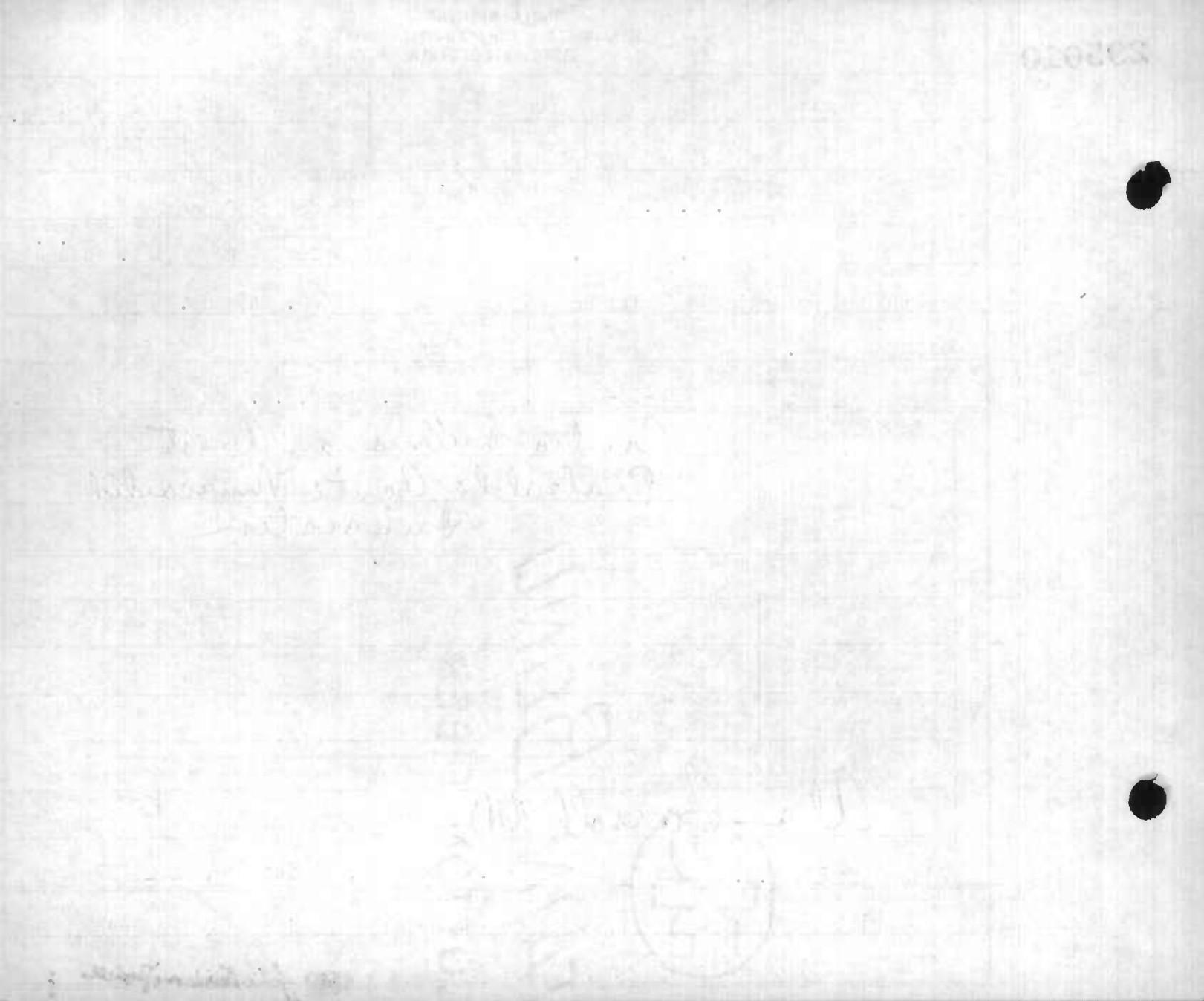
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1- FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	October 5, 1985				9:20am				
Ella Mae FYLER															
3. SEX				4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female				White	January 18, 1897			88 yrs							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland				U. S. A.							Frederick County				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Emmitsburg				524 W. Main St.								Housekeeper			
13a. STATE				13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
Maryland				Frederick	Emmitsburg							524 W. Main St. 21727			
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				16. ADDRESS				
Joseph D. Caldwell							Winina				Md 21727				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT				Margaret W. Baker, P.O. Box 422 Emmitsburg,				
No				214-32-4652											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									<input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.													22c. DATE SIGNED		
22b. SIGNATURE <i>Alan Carroll MD</i>													22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Carroll, M.D.													22e. ADDRESS		
													S. Seton Ave, Emmitsburg, MD 21727		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8 Oct 85			23c. NAME OF CEMETERY OR CREMATORIAL Emmitsburg Memorial				23d. LOCATION CITY OR TOWN Emmitsburg, Frederick, MD					
24. FUNERAL DIRECTOR NAME Skiles Funeral Home, Emmitsburg, MD 21727			ADDRESS			25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
OCT 14 1985 Julie Twiss, R.N.															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be called in to make a report.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>BERTHA MORGAN FANT</i>						<i>10-07-85</i>				<i>1130 AM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>MON 18 1903</i>				6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i>	IF UNDER 1 YEAR <i>MONTHS</i>	IF UNDER 24 HRS <i>DAYS</i>	MD.	
7a. BIRTHPLACE <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Frederick</i>				
10. CITY OR TOWN OF DEATH <i>Frederick</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Frederick Memorial Hospital</i>				12a. USUAL OCCUPATION <i>Secretary</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Gov.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input checked="" type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE <i>7237 Friends Creek Emmitsburg</i>	219029		
14. FATHER'S NAME <i>Benjamin</i>	MIDDLE <i>J.</i>	15. MOTHER'S MAIDEN NAME <i>Bertha</i>	I. MIDDLE <i>I.</i>	LAST <i>Shern</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)	16b. SOCIAL SECURITY NO. <i>215-38-6655</i>	17. INFORMANT <i>Patricia Owens</i>	ADDRESS <i>7237 Friends Creek Emmitsburg</i>							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic terminal endometrial cancer - pulmonary embolism.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant ascites, extensive abdominal metastasis.</i>										
(c) <i>total histology of my resection to neck lymph nodes</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>limit to all work</i>										
19a. DATE OF OPERATION <i>4/26/1985</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Total hysterectomy for malignant ascites</i>	20a. AUTOPSY? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/1/85</i> 19 <i>85</i> , to <i>10/7</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive, on <i>10/7/85</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>NIC</i>										
22b. SIGNATURE <i>Nicholas P. Doris</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>10/8/85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NICHOLAS P. DORIS</i>	22e. ADDRESS <i>27. West 7th St. Frederick Md.</i>									
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	23b. DATE <i>10-9-85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Whitemarsh Mem. Pk</i>	23d. LOCATION CITY <i>Ambler</i> COUNTY <i>Montgomery</i> STATE <i>Pa.</i>							
24. FUNERAL DIRECTOR NAME <i>G. Douglas Stauffer</i>	24b. ADDRESS <i>1624 Opossumtown Pike Fred. Md. 21701</i>	25a. DATE REC'D. BY REGISTRAR <i>MT 77 1985</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Doris</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please staple carbon papers, pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other illomatic event, the medical examiner will be called.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28 / 31

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN TO BE ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
		KELLY RENEE FINNEYFROCK			<input checked="" type="checkbox"/>	10-23-85	19		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR
Female	White	11 4 83	1 yrs.			10-23-85	19		7:15
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			7c. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.			Child Frederick County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <small>IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS</small>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Frederick		Frederick Memorial Hospital			Child			Child	
13a. STATE Md.		13b. COUNTY Frederick	13c. CITY OR TOWN Thurmont	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS 8N. Altamont	13f. CITY OR TOWN Md. 21788	Av. Thurmont		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
James		A.	Finneyfrock	H. Diane		Edwards			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> No		16b. SOCIAL SECURITY NO. 220-04-3370		17. INFORMANT James Finneyfrock		ADDRESS Thurmont, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of right atrium of heart</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:15 P.M. 10-23-85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>fall on child</u> <u>subject fell down stairway at construction site</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 7200 Kellystate Rd. CITY OR TOWN Thurmont, Maryland COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Margarita A. Korell</u>									
EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S TITLE M.D.			MEDICAL EXAMINER 111 Penn Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10-26-85		23c. NAME OF CEMETERY OR CREMATORIUM Bethel Ch. Cemetery Cascade		23d. LOCATION CITY OR TOWN Washington Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer 1621 Opossumtown Pike, Fred. Md. 21701		ADDRESS		25a. DATE REC'D. BY REGISTRAR Oct 29 1985		25b. REGISTRAR'S SIGNATURE <u>Julie Davidson-Pandza</u>			
DHMH - 17 (VR A15 ME (5))									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 32

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST Alice	MIDDLE Mae	LAST FORNEY	2a DATE OF DEATH MONTH October 13, 1985	DAY YEAR	2b HOUR 8:00 AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH March 6, 1908		DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.			
10 CITY OR TOWN OF DEATH Monrovia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12518 Fingerboard Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Monrovia		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 12518 Fingerboard Road 21770	
14. FATHER'S NAME FIRST Robert		MIDDLE Bruce		LAST Thompson		15. MOTHER'S MAIDEN NAME FIRST Etta		MIDDLE LAST Wagner	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 220-30-9457		17 INFORMANT Carol Lee White		28003 Kempton Church Rd. Damascus, Md. 20872		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 years	
<p>18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Serious Methyl Sulfurosis</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) _____</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>97 38</u> to <u>97 38</u>, 19<u>85</u> to <u>97 38</u>, 19<u>85</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.</p> <p>22b. SIGNATURE <u>Robert L. Kaufman, M.D.</u></p> <p>DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></p> <p>22c. DATE SIGNED <u>10/14/85</u></p>									
22d PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Kaufman, M.D.		22e ADDRESS 804 Toll House Ave., Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 15, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Linganore		23d. LOCATION CITY OR TOWN Unionville, Frederick, Md.			
24 FUNERAL DIRECTOR Orin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR OCT 16 1985		25b. REGISTRAR'S SIGNATURE <u>Orin L. Molesworth, P.A.</u>	

LONDON

THE FRENCH

ARMED FORCES

IN THE FIELD OF AIR POWER

BY A MEMBER OF THE AIR STAFF

ARMED SERVICES INFORMATION

THE BRITISH ARMY IN THE FIELD OF AIR POWER

ARMED SERVICES INFORMATION

THE BRITISH ARMY IN THE FIELD OF AIR POWER

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ARMED SERVICES INFORMATION

THE BRITISH ARMY IN THE FIELD OF AIR POWER

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbonpaper. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR					
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	
William M. L. Gaver					
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		White		Sept. 5, 1906	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Frederick		644 Wilson Place			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 644 Wilson Place, 21701			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	
William		Howard	Gaver	Sarah	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. II		17. INFORMANT Mrs. Mary Frances Gaver, Frederick, Md. 21701	
Yes		215-26-1921		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		Asbestosis			
DUE TO, OR AS A CONSEQUENCE OF (b)		years			
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sense of the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated in Part 1.					
22b. SIGNATURE <i>Allen J. Gilson</i>					
22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 10/10/85		
24. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1475 Taney Ave., Frederick, Md. 21701			
Dr. Allen J. Gilson, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Oct 12, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Middleton Lutheran		23d. LOCATION CITY OR TOWN Middleton, COUNTY Frederick, STATE Maryland
Burial					
24. FUNERAL DIRECTOR Richard C.C. Basford Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE Julie Wilson Pendleton	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial/memorial service. Then please send carbons/papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as having been 18 years or older, only injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			Blanche	Ora	Gordon	10	6	85	4:10 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		Caucasian		MONTH	DAY	YEAR	93					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U. S. A.					Frederick,					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Citizen's Nursing Home		Housewife			Homemaker					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Frederick	Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8014 Glendale Dr./ 21701				
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Joseph		D.	Grossnickle		Emma				Stauffer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		219-44-4659		Garland D. Gordon			8014 Glendale Dr., Fred					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary artery disease</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>many years</u> , 19 <u>19</u> , to <u>10/6/85</u> , 19 <u>19</u> , that (I) (we) last saw the deceased alive on <u>10/6/85</u> , 19 <u>19</u> , and that in (my) (<input type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Austin Pearson Jr.</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/8/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10/9/85		23c. NAME OF CEMETERY OR CREMATORIAL Brownsville Cemetery			23d. LOCATION CITY OR TOWN Brownsville COUNTY Washington STATE Md.					
24. FUNERAL DIRECTOR NAME <u>Robert E. Dailey III</u> ADDRESS <u>Robert E. Dailey & Son, P.A.</u>		25a. DATE REC'D. BY REGISTRAR 1201 N. Market Frederick, MD		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Pearson</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do it by _____.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon copy and sign original and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted before the death certificate is signed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 28 / 35				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR			
Bernice Kiracofe Hammaker						09	16	85	11:05 AM					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		Caucasian		12	21	03	81							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.					Frederick MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		Teacher (ret)					Teaching					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21701		
Maryland		Frederick		Frederick		XX			8551B U.S. Rt. 15 North					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Harry		Louden		Kiracofe	Myrtle					Rhoderick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		212-24-5434A		Nancy H. Crum			8551-B U.S. 15N., Fred, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEC515														
DUE TO, OR AS A CONSEQUENCE OF (b) INVESTIGATOR OBSTRUCTION														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					<input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 15 Sept. 1985, to 16 Sept. 1985, that (I) (we) last saw the deceased alive on 16 Sept. 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.														
22b. SIGNATURE George I. Smith Jr., MD, PA		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 15 Sept 85						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
George I. Smith, Jr., MD, PA					804 Toll House Ave., Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		9/20/85		Mt. Olivet Cemetery			Frederick		Frederick		Md.			
24. EMPLOYED DIRECTOR Robert F. Dalton & Son, P.A.		ADDRESS			1201 N. Market Frederick, Md.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Robert F. Dalton & Son, P.A.				
25b. REGISTRAR'S SIGNATURE Robert F. Dalton & Son, P.A.								OCT 15 1985						

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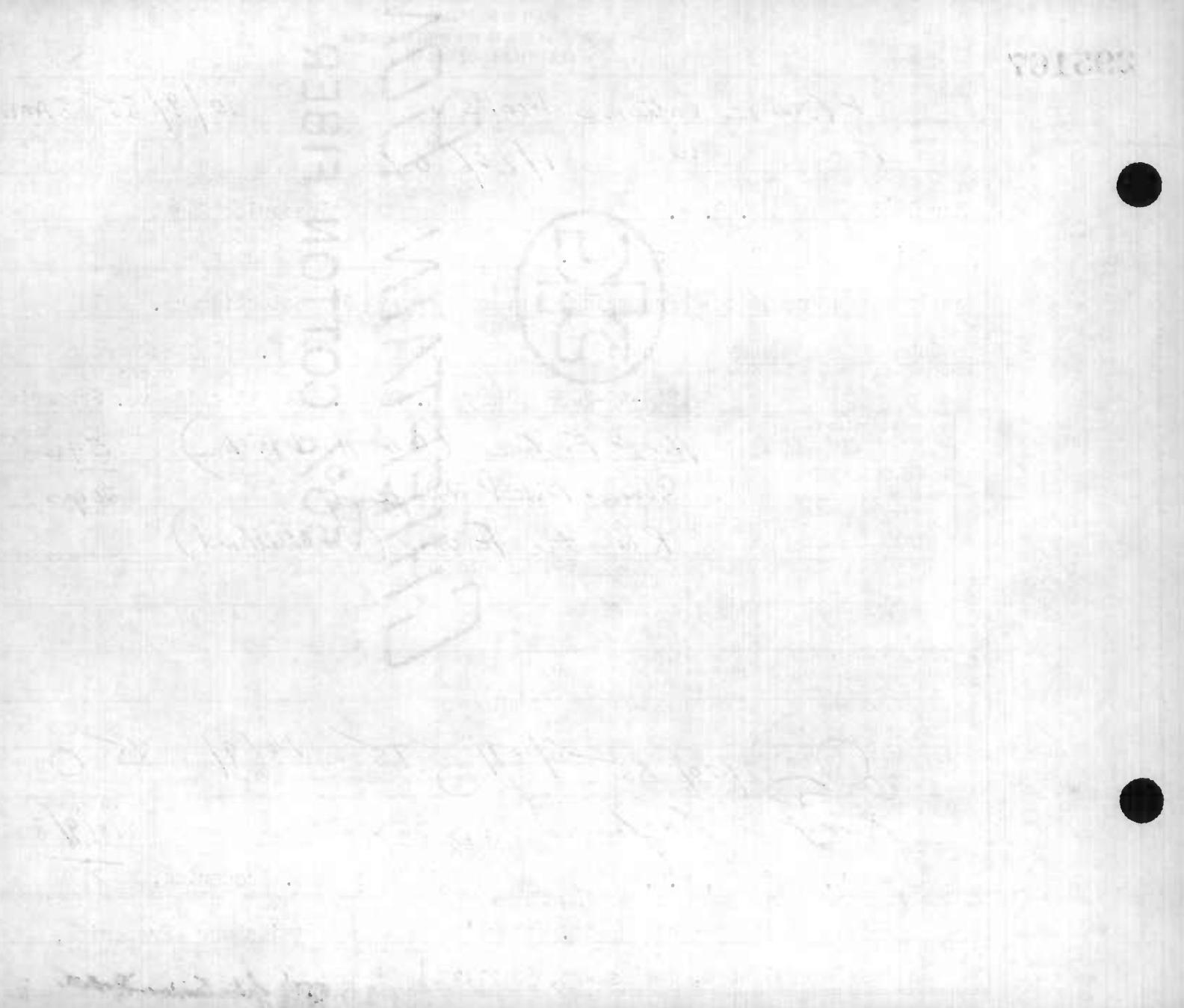
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH
		FIRST	MIDDLE	LAST	MONTH DAY YEAR
		<i>Florence Catherine Hobbs</i>			10 19 85
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)
F		W.	MONTH	DAY	78 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U. S. A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Frederick		351 Catoctin Ave.		Housekeeper	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE
Maryland		Frederick	Frederick	YES <input checked="" type="checkbox"/>	351 Catoctin Ave. 21701
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME
		John	Henry	Hobbs	Martha F. Eckenrode
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		214-48-2606		Harry M. Hobbs. 351 Catoctin Ave. Frederick	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Heart Failure (Cong. Heart Failure)</i>			
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>			
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Senile Arterial Disease</i>			
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs.</i>			
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Rheumatic Fever (in childhood)</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if this hospital) attended the deceased from <i>8/27/85</i> , 19 <i>75</i> , to <i>10/19/85</i> , 19 <i>85</i> , that (I/we) last saw this person alive on <i>7/30/85</i> , 19 <i>85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not touch the body after death.					
22b. SIGNATURE <i>Robert L. Kaufmann, M.D.</i>					
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. ADDRESS 804 Toll House Ave. Frederick, MD 21701					
22e. DATE SIGNED <i>10/19/85</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		12 Oct 85	St. Joseph's		Emmitsburg Frederick, MD
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Skiles Funeral Home, Emmitsburg, MD 21727				OCT 15 1985	<i>John L. Kaufmann, M.D.</i>

202102



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mehrtle Lewis Hobbs Sr.					Hobbs Sr.	10/5/85				0205M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Male		White		Month June 24, 1921 Day Year		64			Months Days			
8. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS			
Maryland		U.S.A.				Frederick County			HOURS MIN.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		Self-employed			Restaurant Prop.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE						
Maryland		Frederick		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13530 Old National Pk 21771			
14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Paul			Ada			213-16-0619			Mrs. Clara E. Hobbs 13530 Old National Pk Mt. Airy, Md. 21771			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 mos						
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease						10 yrs						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
20a. MEDICAL CERTIFICATION			21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 04-30, 1981, to 10-05, 1981, that (I) (we) last saw the deceased alive on 10-04, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE <i>Julio Menocal</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 10-05-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julio Menocal			22e. ADDRESS 516 Trail Ave, Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 8, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens			23d. LOCATION CITY OR TOWN Frederick, Frederick, Md.			
24. FUNERAL DIRECTOR Smith, Keeney & Basford Funeral Home 106 East Church St., Frederick, Md. 21701									25. DATE READ TO REGISTRAR 8/10/85			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be
retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use by the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked as "Yes" on page 18 shows any injury, or other traumatic event, the medical examiner must be
notified.

223102



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITH THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3, RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. JESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

28 / 30

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
			LOUIS	EDWARD	HURT, JR.	<input checked="" type="checkbox"/> 10 25 1985	?			?
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	Sept. 10, 1964				10 25 1985	?			?
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Frederick, Co.			
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Thurmont		Spalding Alley/Thurmont, Md.			Carpenter		Carpentry			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 108 Boundary Ave./21788				
14. FATHER'S NAME Louis		MIDDLE Edward	LAST Hurt	15. MOTHER'S MAIDEN NAME Virginia		MIDDLE Elaine	LAST Brice			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. None			17. INFORMANT 43 Moser Rd. Virginia Hurt			ADDRESS Thurmont Maryland 21788	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gun shot wound, chest, neck</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 25 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <i>Self inflicted G-S-W</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN Thurmont			COUNTY Frederick Md.	STATE Md.	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Robert J. Thomas</i>					TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER 812 Toll House Ave. Frederick, Md. 21701		
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		10-28-1985		Blue Ridge Cemetery		Thurmont		Frederick	Md.	
24. FUNERAL DIRECTOR NAME <i>Robert E. Dailey</i>		ADDRESS		615 E. Main St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert E. Dailey & Son				Thurmont, Md. 21788		NOV 1 1985		<i>Jane Landon Pendell</i>		
DHMH - 17 (VR A15 ME (5))										

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 39

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
FRANCES MARIE HUTTO			OCTOBER 22, 1985	6:50 AM
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH August DAY 9, 1923	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 914 Pine Avenue		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker
13a STATE Maryland		13b COUNTY Frederick	13c. CITY OR TOWN Frederick	12b KIND OF BUSINESS OR INDUSTRY Home
14. FATHER'S NAME FIRST John MIDDLE William LAST O'Neal		15. MOTHER'S MAIDEN NAME FIRST Dorothy MIDDLE LAST Foland		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS George F. Hutto, 914 Pine Avenue, Frederick, Maryland 21701
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALVEOLAR CELL CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 19 69 to OCTOBER 19 85, that (I) (we) last saw the deceased alive on OCTOBER 17 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Dr. George I. Smith, Jr., M.D.		DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Oct. 22, 1985
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George I. Smith, Jr., M.D.		22e ADDRESS 804 Toll House Ave., Frederick, Md. 21701		
23a BURIAL, CREMATION, REMOVAL ISPECIALLY		23b DATE Oct. 25, 1985	23c NAME OF CEMETERY OR CREMATORIALutheran Cemetery	23d LOCATION CITY OR TOWN Middletown, Frederick, Maryland
24 FUNERAL DIRECTOR Robert C. Basford Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a DATE REC'D. BY REGISTRAR OCT 28 1985 25b. REGISTRAR'S SIGNATURE John David Basford		

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 2 and 3 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 show any injury, or other traumatic event, the medical examiner will be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8528 / 40

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Katherine Virginia Jones				10/10/85 10 85				10:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY) YRS			
Female		Caucasian		09/24/02 9 27 02				383 MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA						Frederick County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Memorial Hospital				Housewife		Home			
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE			
Maryland		Howard		Columbia				6150 Foreland Garth 21044			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST Joseph		MIDDLE H. LAST Schafer				FIRST Katherine MIDDLE LAST "Unknown"					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT					
No		N/A 216-42-8420				10809 Days Ville Road Frederick, MD 21701					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Alte Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <u>10/10/85</u> to <u>10/10/85</u> , that (I) we last saw the deceased alive on <u>10/10/85</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (we) did (did not) view the body after death.										22c. DATE SIGNED <u>10/10/85</u>	
22b. SIGNATURE <u>Jeffrey N. Cowen</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey N. Cowen MD				22e. ADDRESS 4 W. 7TH ST Frederick MD					
23a. BURIAL, CREMATION, REMOVAL RECIPIENT		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.				23d. LOCATION Baltimore City, Maryland			
Burial		10/12/85									
24. FUNERAL DIRECTOR NAME <u>MacNabb Funeral Home</u> ADDRESS <u>Catonsville, MD</u>										25a. DATE REC'D. BY REGISTRAR <u>OCT 16 1985</u>	
										25b. REGISTRAR'S SIGNATURE <u>Judithson-Pendle</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 shows any injury, or other traumatic event, the medical examiner must be consulted before signing.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 8 7 4 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
<i>Adolph Thomas Laciak</i>						10	23	85	2:10 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS		
<i>Male</i>		<i>Caucasian</i>		6	9	12	73	YRS.	MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Maryland</i>		<i>U.S.A.</i>					<i>Frederick</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Frederick</i>		<i>806 E. Patrick Street</i>				<i>Ret./Railroad</i>			<i>Railroad</i>		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
<i>Maryland</i>		<i>Frederick</i>		<i>Frederick</i>				<i>806 E. Patrick Street</i>			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST		
<i>Sylvester</i>				<i>Laciak</i>	<i>Caroline</i>				<i>Paydak</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT		ADDRESS			
<i>No</i>		<i>710-09-6563</i>				<i>Beatrice Sigafoose</i>		<i>Box 172, Brunswick, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Cachexia + Cancer</i>											
DOUE TO, OR AS A CONSEQUENCE OF (c) <i>of Lung</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED
22d. PHYSICIAN'S NAME <i>Gerald M. Reed, M.D.</i>					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE	
<i>Burial</i>		<i>10-26-85</i>		<i>Mt. Olivet Cemetery</i>			<i>Frederick</i>		<i>Frederick</i>	<i>Md.</i>	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE
<i>Robert E. Dailey III</i>		<i>1201 N. Market</i>			<i>OCT 28 1985</i>						<i>Robert E. Dailey & Son, P. A. Frederick, Md.</i>

620500

1947-1948
1948-1949



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or [] shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>MARGARET Olevia Lease</i>						<i>OCTOBER 20, 1985</i>				<i>1:45 P.M.</i>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>Female</i>		<i>White</i>		<i>March 6, 1897</i>		<i>88</i>		<i>7</i>	<i>14</i>	<i>MONTHS</i>	<i>HOURS</i>		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
<i>Maryland</i>		<i>U.S.A.</i>				<i>Frederick Co.,</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Frederick</i>		<i>Meridian Nursing Center</i>				<i>Bookkeeper & Clerk</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21791			
<i>Maryland</i>		<i>Frederick</i>		<i>Union Bridge</i>				<i>13702 Unionville Rd.</i>					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
<i>Gideon</i>		<i>Thomas</i>		<i>Lease</i>		<i>Dora</i>		<i>Olevia</i>		<i>Miller</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
<i>No</i>		<i>213-38-5238A</i>		<i>Nancy E. Tysdal, 2614 Higbee Rd.</i>		<i>Adelphi, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Alzheimer's disease</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>JUNE 19 84</i> to <i>OCTOBER 19 85</i> , that (we) lost saw the deceased alive on <i>OCTOBER 20 19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>George L. Smith Jr. MD.</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Oct. 21, 1985</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-23-1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Linganore</i>		23d. LOCATION CITY OR TOWN <i>Unionville</i>		COUNTY <i>Frederick</i>		STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Charles W. Burrier, Jr.</i>		ADDRESS <i>Sykesville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 24 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

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#1, per F.H. 10/15/85, kam

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 43

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<u>Georgeine Spline Lee</u>				<u>George</u>	<u>Spline</u>	<u>Lee</u>	<u>October</u>	<u>9</u>	<u>1985</u>	<u>2355 P.M.</u>	
3. SEX <input checked="" type="checkbox"/> Female		4. RACE <input checked="" type="checkbox"/> White		5. DATE OF BIRTH MONTH <u>Aug.</u> DAY <u>31</u> , YEAR <u>1911</u>		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
						<u>74</u> YRS		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Frederick County,</u>		MD.			
10. CITY OR TOWN OF DEATH <u>Frederick</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Frederick Memorial Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>State Government</u>					
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Frederick</u>		13c. CITY OR TOWN <u>Buckeystown</u>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE <u>Buckeystown, Maryland 21717</u>			
14. FATHER'S NAME FIRST <u>Philip</u>		MIDDLE <u>F.</u>		LAST <u>Lee</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Margaret</u>		MIDDLE <u>Wilson</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>None</u>		16c. INFORMANT <u>Seymour B. Stern</u>		118. ADDRESS <u>West Church Street</u>		ADDRESS <u>Frederick, Maryland 21701</u>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) <u>bilateral pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause, lost. (1b) <u>pan cytopenia</u>											
DUE TO, OR AS A CONSEQUENCE OF (1c) <u>Chemo therapy</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>76</u> , to <u>October</u> , 19 <u>85</u> , that (II) (I) saw the deceased alive on <u>9 October</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. George I. Smith, Jr., M.D.</u>		22c. DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>10 Oct 85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>804 Toll House Ave., Frederick, Md. 21701</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> Burial		23b. DATE <u>Oct. 32, 1985</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Joseph's Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Buckeystown</u>		CITY OR TOWN <u>Frederick</u>		COUNTY <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Richard C. Basford</u>		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>John J. Keeney</u>							
Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completed within 24 hours after death. Page 4 may be
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner
should be notified for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

referred by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completed within 24 hours after death. Page 4 may be
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner
should be notified for use as the burial-transit permit. Then please remove certain pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME JAMES James ALVA ALVA LEISTER LEISTER				2a. DATE OF DEATH October 27 1985	MONTH 10	DAY 27	YEAR 1985	2b. HOUR 5:12 PM
3. SEX MALE		4 RACE WHITE	5. DATE OF BIRTH 01/18/07	6 AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 5 MIN. 12	
7a. BIRTHPLACE STATE OR FOREIGN MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK		
10 CITY OR TOWN OF DEATH FREDERICK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FREDERICK MEMORIAL HOSPITAL			12a. USUAL OCCUPATION WELDER		12b. KIND OF BUSINESS OR TRADE SELF EMPLOY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD STATE CARROLL		NEW WINDSOR		NO INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS 1701 OLD NEW WINDSOR PIKE		
15. FATHER'S NAME JAMES F. LEISTER		LAST	16. MOTHER'S MAIDEN NAME ANNA MARY EVERHART					
17. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		18b. SOCIAL SECURITY NO. 213-05-2735	17. INFORMANT CORINNE BUTLER LEISTER		ADDRESS 1701 OLD NEW WINDSOR PIKE			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIO - RESPIRATORY FAILURE						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) (E) - middle cerebro l. A.						
		(c) On face too.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 19 DAY 19 YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 10/27/85 , 19 85 , to 10/27/85 , 19 85 , that (I) (we) last saw the deceased alive on 10/18/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Prafull Dave		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PRAFULL DAVE		22e. ADDRESS T88 Thomas Johnson dyng						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/31/85	23c. NAME OF CEMETERY OR CREMATORIAL KRIDERS CEMETERY		23d. LOCATION WESTMINSTER CARROLL		FED. MD	
24. FUNERAL DIRECTOR D. D. HARTZLER		25a. DATE REC'D. BY REGISTRAR NOV 01 1985		25b. REGISTRAR'S SIGNATURE Lorraine Pendleton				
25c. PRELIMINARY								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Then please remove carbon copies. Pages 1 and 2 should be held until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 45

288003

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
			Aileen	E.	MARLOW	10/4/85				21:30A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			7. UNITS
Female		White		Sept. 16 1909		76	MONTH	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		9 BALTIMORE CITY OR COUNTY OF DEATH				
Michigan		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Frederick County, MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
Frederick		7013 Basswood Drive		Mathematician		U.S. Gov.				
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Frederick Frederick				7013 Basswood Dr. 21701				
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME					
		August		Ohtenen	Ida					
Lehtonen										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17 INFORMANT Mrs. Karen L. Howser, 1220L Gemini Dr., Annapolis, Maryland 21403		ADDRESS				
no		217-36-7783								
								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal arrest</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Excessive hypertension</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>with brain & bone mets</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>10/4/85</u> to <u>10/4/85</u> , 1985 (we) last saw the deceased alive on <u>10/11/85</u> and (we) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.										
22b. SIGNATURE <u>S. J. Brown</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>10/5/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. J. Brown</u>		22e. ADDRESS <u>4 West Germany</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 6, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory		23d. LOCATION CITY OR TOWN Smithsburg, Md.				
24 FUNERAL DIRECTOR Smith Keeney		25a. DATE REC'D. BY REGISTRAR 8/1985		25b. REGISTRAR'S SIGNATURE <u>J. L. Johnson</u>						
Basford P. Mass Funeral Home 106 E. Church St., Frederick, Md. 21701										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be handwritten filled in by the funeral director page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Item 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

COPIES

22

305132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be detached for use with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Stanley J. Meadows						10	22	85	3:10 AM										
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. # UNDER 24 HRS HOURS MIN.							
Male		White		11	10	97	87	YRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Maryland		U.S.A.					Frederick												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Meridian Nursing Ct. Fred.										Dentist		Dentistry					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE		21701											
Maryland		Frederick		Frederick		301 College Pl. Fred. Md.													
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST									
		John	E.	Meadows				Anna	L.	Darr									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS												
No							Katherine G. Meadows Fred. Md. 21701												
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19b and 19c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Cardiac arrest																			
DUE TO, OR AS A CONSEQUENCE OF (b) advanced atherosclerotic heart disease																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first																			
DUE TO, OR AS A CONSEQUENCE OF (c) disease																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												5 years							
Organic brain syndrome																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (the hospital) attended the deceased from July 19 60 to Oct 22 19 85, that (I) (we) last saw the deceased alive on Oct 21 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED Oct 22, 1985							
In Signature Henry V. Chase MD												DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Henry V. Chase MD		804 Toll House Ave Frederick																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE							
Cremation		10-23-85		Smithsburg Crematory			Smithsburg			Washington		Md.							
24. FUNERAL DIRECTOR NAME		G. Douglas Stauffer		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
		1621 Opossumtown Pike Fred. Md. 21701					Oct 28 1985			John Kline									
DHMH - 16 60M 7-B4 (VRA 15, 4)																			

302195

REASONABLE CONDITION



289102

85 28 / 47

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	3:20		
			James	Edward	MILLER, SR.	October 3, 1985			P. M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		MONTH Dec. DAY 29 YEAR 1910		74			MONTHS DAYS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS				
Maryland		U.S.A.				Frederick County,			MONTHS HOURS MIN.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Mem. Hospital		Maintenance		County Gov.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			223 East Third St. 21701				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
		Unknown						Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		WW II		Mrs. Margaret E. Miller, 223 East Third St., Frederick, Md. 21701						2 weeks			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD + High BP</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a <u>M.I. old - acute pneumonia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18-</u> 19 <u>55</u> , to <u>10-3-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>10-3-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Rex R. Martin, M.D.</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-4-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Rex R. Martin, M.D.		22e. ADDRESS 220 North Market St., Fred. Md. 21701											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 7, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Linganore Cemetery		23d. LOCATION CITY OR TOWN Unionville		COUNTY Fred. Md.		STATE			
24. FUNERAL DIRECTOR Smith Keeney Basford Funeral Home, 106 East Church St. Frederick, Maryland 21701						25a. DATE REC'D. BY REGISTRAR 8-18-85		25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

SOURCE



295082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician, and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8528748							
										REG. NO.							
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR 1:50P 2:50A							
		LYMAN		EARL		MYERS		10/10/14/85									
		MALE		WHITE		5. DATE OF BIRTH 10/16/25		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.					
		MARYLAND		U.S.A.		7a. BIRTHPLACE STATE OR FOREIGN		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED M		NEVER MARRIED D		WIDOWED D		DIVORCED D	
		FREDERICK		FREDERICK MEMORIAL HOSPITAL		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION GOVERNMENT		12b. KIND OF BUSINESS OR NAVAL HOSP.					
		MD		LIBERTYTOWN		13. ADDRESS MD		14. FATHER'S NAME BENJAMIN H. MYERS		15. MOTHER'S MAIDEN NAME VALLIE HEINER		16. STREET ADDRESS ZIP CODE 21762					
		YES		WW II		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 219-20-2223		17. INFORMANT EDITH L. MYERS		ADDRESS 12054 MAIN ST.					
		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Intestinal Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General anesthesia, Cardiotomy & Thigh Draft 5 days</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>By Hangout - Post Pain</u> (d) <u>Severe Peripheral Vascular Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs					
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
MEDICAL CERTIFICATION		19a. DATE OF OPERATION 10/3/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Above</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
		22b. SIGNATURE <u>Lorin E. Busselberg MD</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 10/15/85									
		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1475 TANEY AVE. FREDERICK, MD													
		23a. BURIAL, CREMATION, REMOVAL 1. BURIAL		23b. DATE 10/17/85		23c. NAME OF CEMETERY OR CREMATORIUM FAIRMOUNT CEMETERY		23d. LOCATION LIBERTYTOWN		23e. FRED.		MD					
		24. FUNERAL DIRECTOR D. D. HARTZLER		25a. DATE REC'D. BY REGISTRAR OCT 18 1985				25b. REGISTRAR'S SIGNATURE									

CHOICES

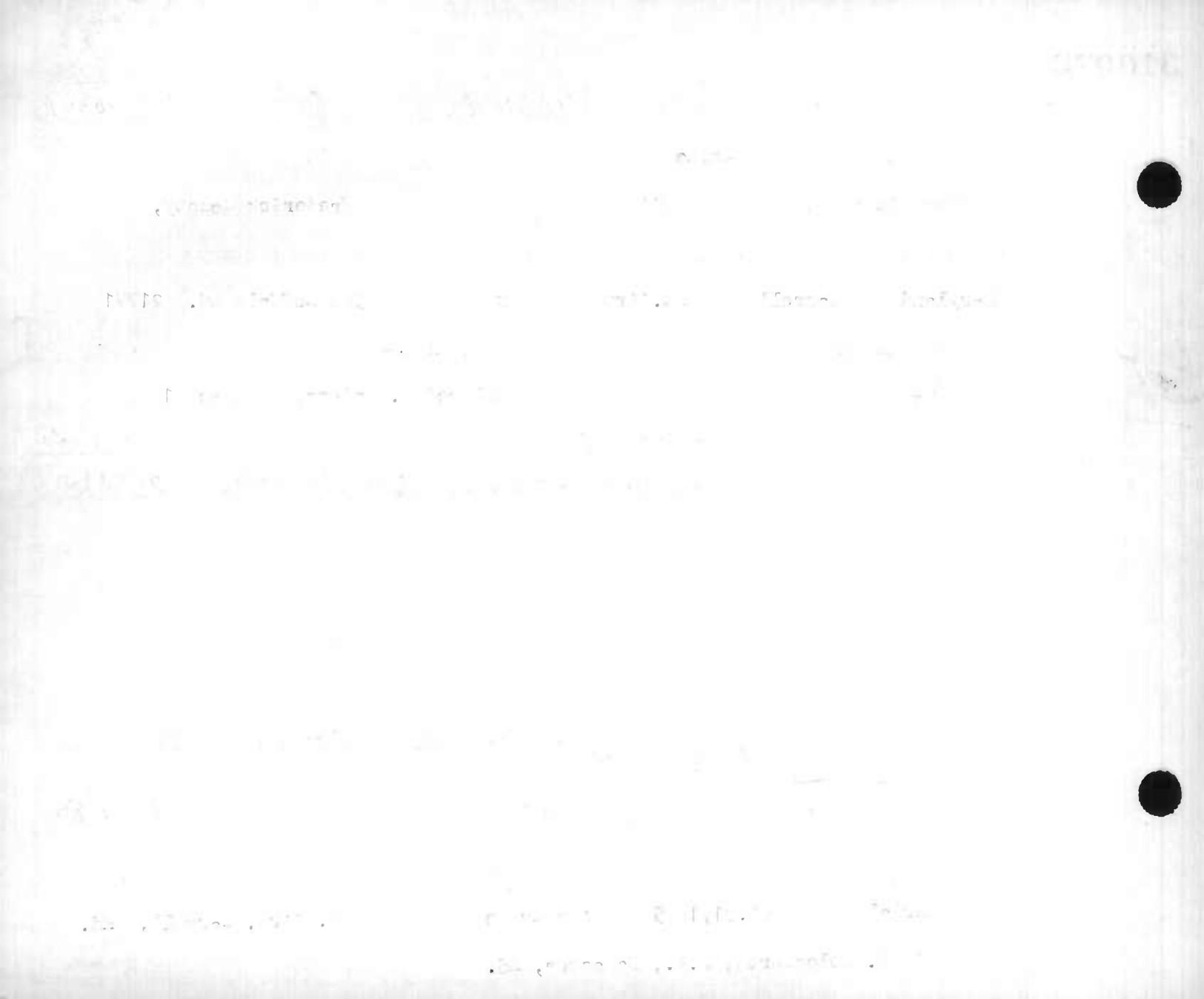
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

310072

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 28 / 49					
1. DECEASED NAME (TYPE OR PRINT)			Lillian Alma Nicholson			2d DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
3. SEX female			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR 9/10/96			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Libertytown Md.			7b. CITIZEN OF WHAT COUNTRY? yes USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, Md.						
10. CITY OR TOWN OF DEATH Fred. Md.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) sewing factory			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland			13b. COUNTY Carroll			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 504 Buffalo Rd. 21771						
13f. FATHER'S NAME FIRST MIDDLE LAST Charles Etzler			13g. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Appleby												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-10-8458			17. INFORMANT Mildred N. Haines, Item 13			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes					
(b) <i>Complete Heart Block (with pacemaker)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										2 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 26, 1984</i> , to <i>Oct. 29, 1985</i> , that (I) (we) last saw the deceased alive on <i>Oct. 28, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Bernard O. Thomas Jr.</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 10/29/85						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) B.O. Thomas Jr.			22f. ADDRESS 228 N. Mkt. St. Fred. Md. 21701												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 31, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove			23d. LOCATION CITY OR TOWN Mt. Airy, Carroll, Md. COUNTY STATE						
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.			25a. DATE REC'D. BY REGISTRAR NOV 04 1985			25b. REGISTRAR'S SIGNATURE <i>Anderson Pendle</i>									
ADDRESS															



298123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

executed within 24 hours after death. Page 3 and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2 should be filed within 72 hours after death.

BP _____
DMHM - 16 60M 7/B4
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28750

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
<i>HARRY LEWIS OWENS</i>						10/19/85			6 AM		
3. SEX <i>M</i>		4. RACE <i>Male Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 13, 1925</i>		6. AGE IN MONTHS (TODAY) <i>59</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 14 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Frederick,</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Frederick</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Frederick Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Engine Mechanic</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Frederick</i>		13c. CITY OR TOWN <i>Libertytown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Jones Road 21762</i>			
14. FATHER'S NAME FIRST <i>Harry</i>		MIDDLE <i>S.</i>	LAST <i>Jones</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Lillian</i>		MIDDLE <i>May</i>	LAST <i>Owens</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-20-9975</i>		17. INFORMANT <i>Mr. Gerald W. Roberts, Sr.</i>		ADDRESS <i>P.O. Box # 4 Libertytown, Md.</i>					
III. CAUSE OF DEATH (Enter only one cause per line for 18a, b, c, d, e, f, g, h, i, j, k, l, m, n, o, p, q, r, s, t, u, v, w, x, y, z.) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (i) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (i), stating the underlying cause, lost. (ii) DUE TO, OR AS A CONSEQUENCE OF (iii)						APPROXIMATE INTERVAL BETWEEN DEATH AND AUTOPSY <i>3 mos.</i>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>COPD</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (i) (the hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (ii) (we) lost son, the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Allen J. Gilson</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>10/19/85</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>10-21-1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Smithsburg Crematory</i>		23d. LOCATION CITY OR TOWN <i>Smithsburg, Washington, Md.</i>					
24. FUNERAL DIRECTOR <i>John D. Dally & Son, Inc.</i>		24a. ADDRESS <i>1201 N. Market Street Frederick, Md. 21701</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 24 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John D. Dally</i>					

CS1863

apple

new England

to New England



1863

W.M. DAVIS & CO., NEW YORK

296182

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. RACES AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

28151

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Lennis Franklin Pittinger						<input checked="" type="checkbox"/>	10	8	1985	?
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Caucasian	10 26 17	67 yrs.	MONTHS	DAYS	HOURS	MIN			30 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		NEVER MARRIED	WIDOWED	XX	DIVORCED
Maryland		U. S. A.			<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Thurmont		134 Water St.,					Ret. Carpenter			Nat. Park Ser
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland	Frederick	Thurmont	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	134 Water Street/ 21788					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
Elmer		James	Pittinger	Ethel		Mills	Tressler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT						
		212-14-6965		Charles E. Pittinger		12 Lombard St., Thu				
18. CAUSE OF DEATH (Enter only one cause per line) (b) and PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Mycobacterium</i>									APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>Atherosclerotic Cardiovascular Disease</i> (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?	
									YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Robert J. Thomas ACTUAL SIGNATURE									M.D. Deputy	
									TITLE (SPECIFY) MEDICAL EXAMINER 812 Toll House Ave. Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Memorial Grdns.		23d. LOCATION CITY OR TOWN Frederick		COUNTY	STATE	
24. FUNERAL DIRECTOR		ADDRESS Robert E. Dailey Jr.		ADDRESS 1201 N. Market St.		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		
								J. L. Wilson		

231902

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR					
HARRY L. RHEA			Jr.			10 - 28 - 85				1:30 P.M.					
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.						
M	W	MONTH	DAY	YEAR	86										
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH									
Washington D.C. U.S.A.						Frederick MD.									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b KIND OF BUSINESS OR INDUSTRY						
Frederick	Meridian Nursing Home			Salesman					Cubiod Co.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e STREET ADDRESS ZIP CODE									
13. STATE	14. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	Germantown Md. 20767									
Maryland	Montgomery	Germantown				Crystal Rock Drive.									
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
Harry	Lee	Rhea		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS								
No				(IF YES, GIVE WAR OR DATES)	577-07-2588	James Rhea	Boyd's Md. 20841 Barnesville Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PNEUMONIA						1 WEEK									
DUE TO, OR AS A CONSEQUENCE OF (b) STROKE (ACUTE CEREBRO VASCULAR)						17 DAYS									
DUE TO, OR AS A CONSEQUENCE OF (c) ACCIDENT															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.o.															
SENILE DEMENTIA, CHRONIC URINARY TRACT INFECTION															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	P.M. 19														
22a. I certify that (I) this hospital attended the deceased from MAR 19 1985 to OCT 28 1985 , that (I) we last saw the deceased alive on OCT 28 1985 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did/did not view the body after death.															
22b. SIGNATURE	DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED								
Brian P. Massaro M.D.											10/28/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS														
BRIAN P. MASSARO						198 Thomas Johnson Dr; Frederick, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	23e. COUNTY					23f. STATE				
Burial	10-30-85	Potomac Meth. Ch.			Potomac	Montgomery					Md.				
24. FUNERAL DIRECTOR NAME	G. Douglas Stauffer ADDRESS			25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE						
									Doddell						
DHMH - 16 60M 7/84 (VRA 15, 4)															

1970-1971

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X G.M. ~~swamp~~ Ranch

HOSPITAL OR ATTENDING PHYSICIAN). The law requires that the death certificate be within 24 hours after death. Page 4 may be

ONE TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper and file this page in your office. No burial permit will be issued without this page.

IMPC87A-1: Item 21 is marked as item 18 shows any injury, or other traumatic event that has been examined.

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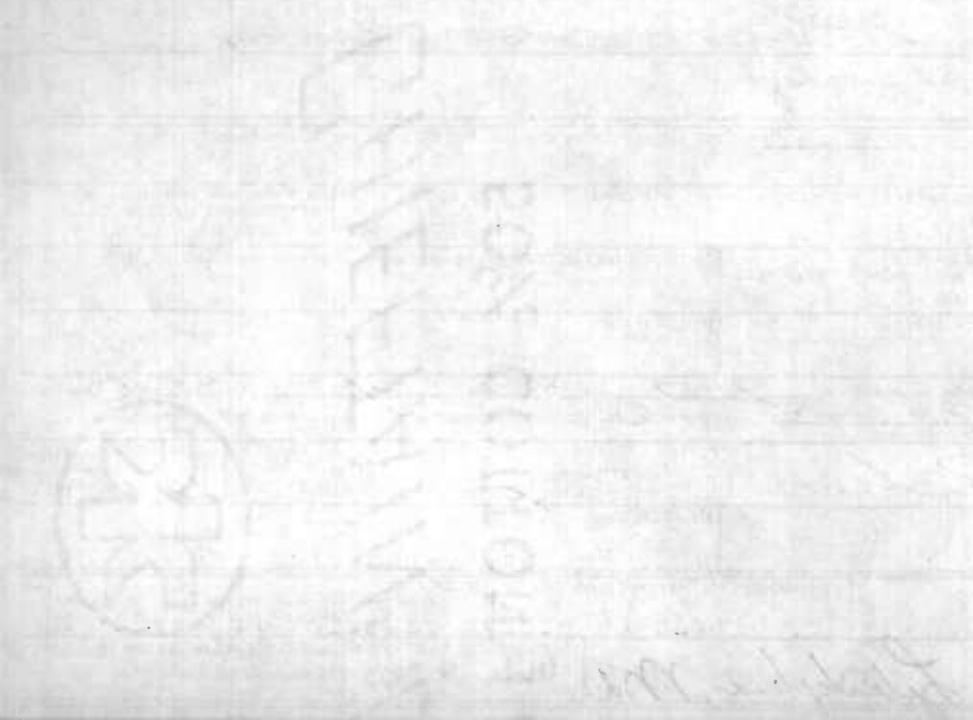
11

FOR
STATE
REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2008-09 - U.S. COUNCIL

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	MONTH	DAY	YEAR	2b. HOUR
Cynthia Virginia Rhoderick							10	1	85	12:33 A
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	8. IF UNDER 24 MRS.					
Female	White	MONTH DAY YEAR 2 9 14	71 YRS.	MONTHS DAYS	HOURS MIN.					
7a. BIRTHPLACE COUNTRY	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia	U.S.A.	Frederick MD								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Frederick	8003 Chestnut Grove Rd.			seamstress			Clothing mfg.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						21701				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland	Frederick	Frederick			8003 Chestnut Grove Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James Edward Overstreet			Minnie Mary Kahle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT Glenn Rhoderick			ADDRESS 8003 Chestnut Grove Rd. Frederick MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>lung disease</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. } (b) <i>excessive colon carcinoma</i>						6 MO				
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR F.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) this hospital attended the deceased from <u>July 19</u> 1985 to <u>Oct 1</u> 1985 that (I) we lost saw the deceased alive on <u>Sept 26</u> 1985 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death.										
22b. SIGNATURE <i>Rausch</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>10/1/85</u>				
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS								
P. Gregory Rausch		4 W. 7th St., Frederick, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 10/3/85		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick		STATE MD		
24. FUNERAL DIRECTOR <i>D. D. Hartke</i>		23e. ADDRESS <i>Liberation, Md.</i>		23f. DATE REC'D. BY REGISTRAR Oct 4 1985		23g. REGISTRAR'S SIGNATURE <i>Janice Hartke</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The I retained by the hospital or attending physician.

Headline and completely filled in by the funeral director, page 3
Pages 1 and 2 should be filed within 72 hours after death

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRATION

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
Russell James Rinehart						October 1, 1985				2:35 P.M.		
3. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male	White	Month Oct. Day 18 Year 1909			75	MONTHS	YEARS	HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.					Frederick County, MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION			12b KIND OF BUSINESS OR INDUSTRY			
Frederick			Frederick Memorial Hospital			Line Foreman			Power Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE						
Maryland	Frederick	Frederick	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>		419 Columbus Ave., 21701						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST Wilbert	MIDDLE	LAST Rinehart	FIRST Ada			MIDDLE Brust						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) [If Yes, Give War or Dates]			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
No			214-10-4113			Mrs. F. Evelyn Rinehart, 419 Columbus Ave., Frederick, Maryland 21701						
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>prob a very large heart</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>prob adeno ca with mets</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>as primary lung liver spleen bone</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 6/15</u> , 19 <u>85</u> , to <u>Oct 1</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Oct 1</u> , 19 <u>85</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we)(did) (did not) view the body after death.												
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
<u>Dr. P. Gregory Rausch M.D.</u>									<u>10/1/85</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS										
Dr. P. Gregory Rausch M.D.		4 West 7th St., Fred. Md. 21701										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		23e COUNTY		23f STATE		
Burial		Oct 4, 1985		Mt. Olivet Cemetery		Frederick		Frederick		Md.		
24. FUNERAL DIRECTOR Smith Keeney Bassford Funeral Home 106 E. Church St., Frederick, Md. 21701		ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
<u>Julie L. Johnson</u>				<u>Oct 6, 1985</u>								

SS0835

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper from back of page 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene. If you prefer to burial, cremation, or other arrangement, mark item 18 and attach a medical statement which will be required if the death certificate is filed within 72 hours after death.

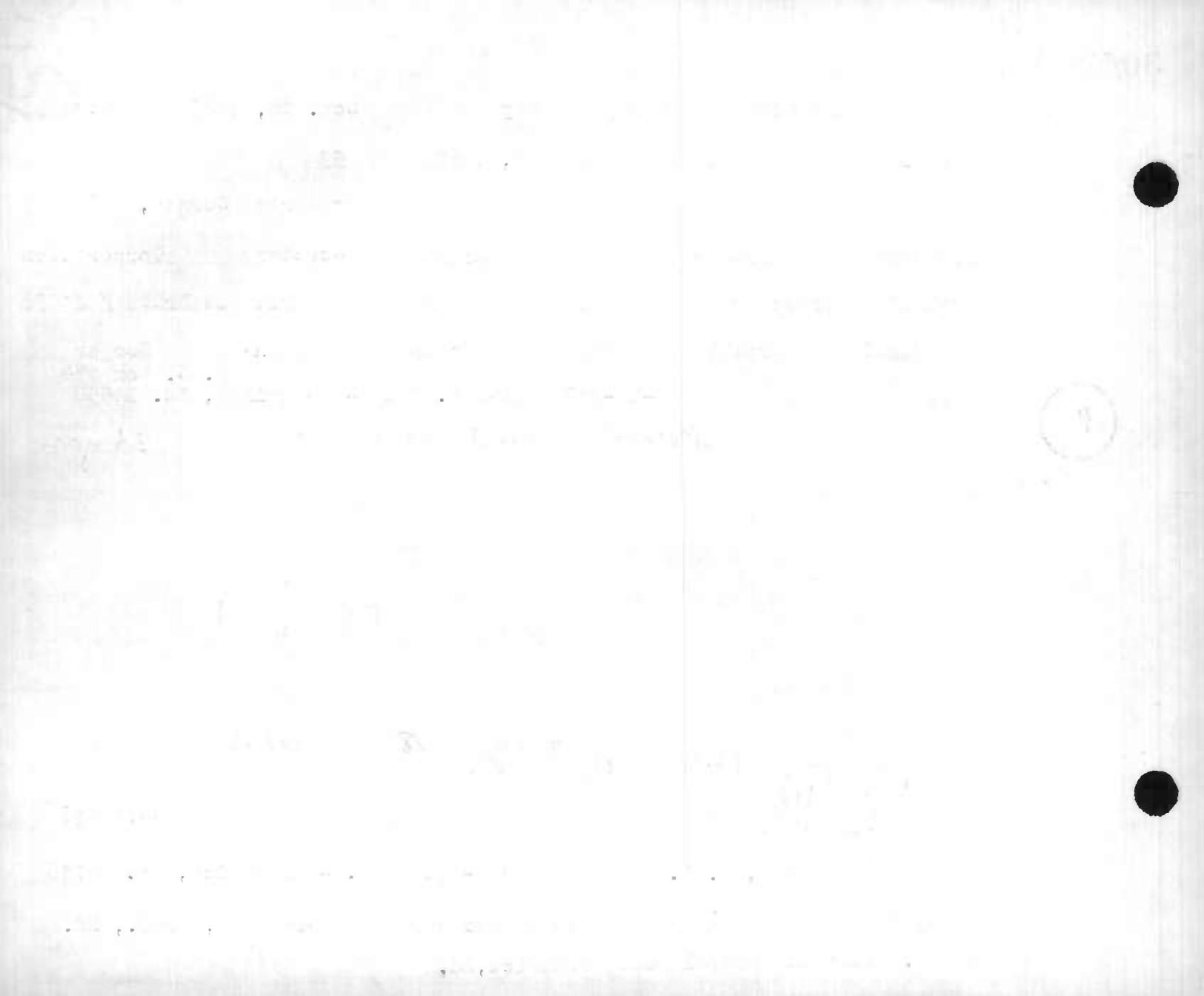
IMPORTANT: If item 21 is marked or item 18 is checked, attach a medical statement.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 55

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Oct. 18, 1985										8:13 PM	
Garnetta Ella May Rudy																	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)								
						June 9, 1932			53 YRS.								
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.								
10. CITY OR TOWN OF DEATH Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Corporation								
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Knoxville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 707 Tritapoe Drive / 21758					
14. FATHER'S NAME FIRST Jessie			MIDDLE Parsell			LAST Rohrback			15. MOTHER'S MAIDEN NAME FIRST Daisy			MIDDLE Malina			LAST Cooper		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-28-5105			17. INFORMANT Alan F. Rudy - Knoxville, Md. 21758			ADDRESS P. O. Box 154								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			Metastatic breast carcinoma						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c))																	
DUE TO, OR AS A CONSEQUENCE OF																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) saw the deceased alive on 10/19/85 and that (I/we) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. SIGNATURE <i>L. Meyer</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/21/85								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 610 - 9th Ave. - Brunswick, Md. 21716														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/22/85			23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery			23d. LOCATION CITY OR TOWN Knoxville, Fred., Md.			23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE <i>OCT 24 1985 John T. Williams Funeral Home Brunswick, Md.</i>	
24. FUNERAL DIRECTOR John T. Williams Funeral Home Brunswick, Md.			ADDRESS NAME														



298006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 56

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR	26 HOUR
Clarence E. Sauble			10 14 85	M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
		12 1 97	87	YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick Co. MD.	
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13a. STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN New Windsor	13e. STREET ADDRESS / ZIP CODE 2354 Old New Windsor Pike 21776	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
John M. Sauble	Lillie M. Cofield	ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 220-05-5891	17. INFORMANT Mrs. Pauline Doffmeyer, New Windsor, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 71 months	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diseases</u> <u>cancer</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) _____				
DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) saw the deceased alive on 10/13/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 10/13/85 to 10/14/85, that (we) last saw the deceased alive on 10/13/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.				
22b. SIGNATURE <u>William O. Miller, MD</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William O. Miller, MD</u>	22e. ADDRESS <u>1475 Taney Ave Frederick, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10-17-85	23c. NAME OF CEMETERY OR CREMATORIAL Black Rock Cemetery	23d. LOCATION CITY OR TOWN Butler	COUNTY Balto STATE Md.
24. FUNERAL DIRECTOR NAME <u>Eline Funeral Home, Hampstead, Md.</u>	ADDRESS	25a. DATE REC'D. BY REGISTRAR OCT 24 1985	25b. REGISTRAR'S SIGNATURE <u>J. L. Johnson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified within 24 hours after death. Page 4 may be

within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	7b. HOUR					
Anthony J.					Scaletta	October 23, 1985			1 A.M.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male		White		6 24 12			73 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Cumberland Md.		U.S.A.						Frederick							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		1308 Taney Ave.			Supervisor			Manufacturing							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Md.		Frederick		Frederick		YES <input checked="" type="checkbox"/>		1308 Taney Ave. 21701							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Anglo				Scaletta		Sarah				Gardner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				214-05-9731		Helen Scaletta Frederick, Md. 21701									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) TERMINAL METASTATIC LARYNGEAL CANCER												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first		DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-21-85 to 10-25-85, that (I) (we) last saw the deceased alive on 8-21-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														22c. DATE SIGNED 10-23-85	
22b. SIGNATURE <i>Cuthar G. Novak</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anstar G. Novak, M.D.			22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (IF)		23b. DATE Burial Oct. 25, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Zion Memorial P.			23d. LOCATION CITY OR TOWN Cumberland Allegany			CITY OR TOWN COUNTY MD					
24. FUNERAL DIRECTOR NAME William G. Kight		ADDRESS Cumberland, MD			25a. DATE REC'D. BY REGISTRAR OCT 28 1985			25b. REGISTRAR'S SIGNATURE <i>John Johnson</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, then please remove carbon paper. Form 1 and 2 should be filed with 72 hours after death.

IMPORTANT: If Item 21 is marked as "Yes", attach a copy of the death certificate to the medical record.

303061

Mississ G. Ridge Computerizing MD
partisi Oct. 25, 1982 by Memotest P. Computerizing VITIABADAY

295092

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
						Oct. 7, 1985				4:15 P.M.		
3. SEX			RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
Female			White	MONTH	DAY	YEAR	85	YRS.	MONTHS	DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.			U.S.A.					Frederick Co. MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frederick			Frederick Memorial Hospital		housewife			own home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 118 W. Green St. 21769			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			
HOWARD L. HUFER						MARY ELLEN MOSER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			214-48-4827		Floyd Schroyer			Jefferson, Md.			24 Hours	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
SEPSIS												
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF OVARY												
DUE TO, OR AS A CONSEQUENCE OF (c)												
> 3 wks.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Acute renal failure												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b.					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-23 1985, to 10-7 1985, that (I) (we) last saw the deceased alive on 10-7 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>James L. Roessler MD</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 10-11-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James L. Roessler MD</i>		22e. ADDRESS P.O. Box 17 MIDDLETOWN, MD. 21769										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 10, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery		23d. LOCATION CITY OR TOWN Middletown			23e. COUNTY Fred. Md.			
24 FUNERAL DIRECTOR NAME Thompson Funeral Home		24b. ADDRESS Middletown, Md.		25a. DATE REC'D. BY REGISTRAR Oct. 18 1985			25b. REGISTRAR'S SIGNATURE <i>James L. Roessler</i>					
BP _____												
DHMH - 16 50M 4/B3 (VRA 15, 4)												

287093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be held at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 28 / 59			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Rose					Shearman	Oct. 2			1985			1:35 PM			
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			W		MONTH 2 DAY 1 YEAR 04	81			MONTHS	DAYS	HOURS	YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
England			U.S.A					Frederick County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Frederick Md.			Citizens Nursing Home			Domestic									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md			Fred		Frederick				2200 Rosemont Ave. 21701						
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Walter Shearman					Kate										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
No			217-32-7269												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO OR AS A CONSEQUENCE OF Diabetes												20 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO OR AS A CONSEQUENCE OF (b) Diabetes															
(c) Peripheral Vascular Disease															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1 Oct. 1983, to 10 Oct. 1985, that (I) (we) lost saw the deceased alive on 10 Oct. 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Bernard O. Remond			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Oct. 1985						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS 228 N. Market St. Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Removal			10/2/85												
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Anatomy Board			Balto., Md.			OCT 9 1985			Julia Davidson Rendell						

Georgia



318005

8 5 2 8 / 6 0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

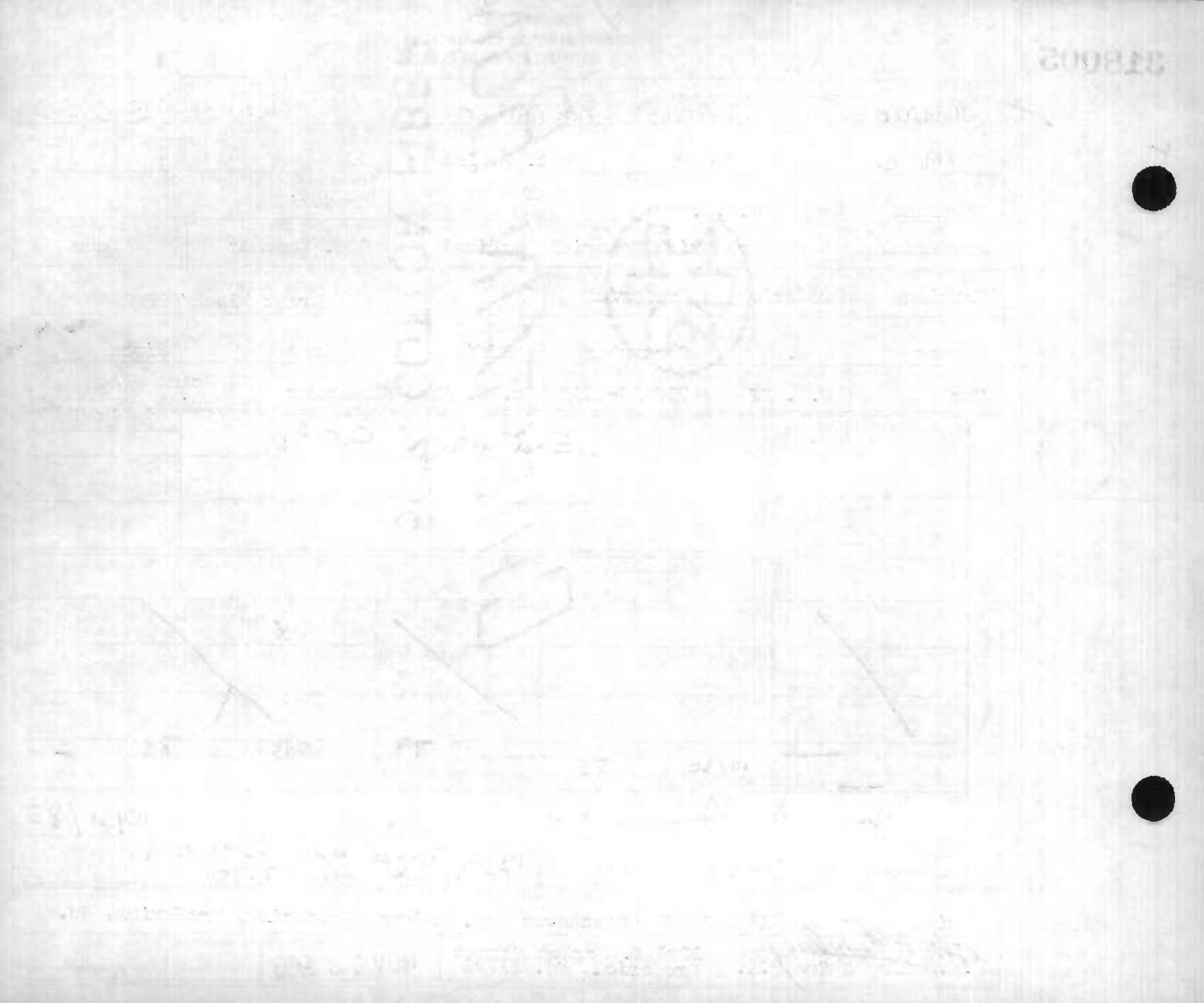
1. DECEASED NAME GEORGE <i>George</i>			MIDDLE THOMAS <i>Thomas</i>	LAST SHOEMAKER <i>Shoemaker</i>	2a DATE OF DEATH Oct. 31 1985	MONTH DAY YEAR	2b HOUR 0950a		
3 SEX Male	4 RACE White	5. DATE OF BIRTH Sept. 7, 1919	6. AGE (IN YEARS LAST BIRTHDAY) 66	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick, MD.						
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Frederick Memorial Hospital			12a USUAL OCCUPATION Ret. Teacher		12b KIND OF BUSINESS OR INDUSTRY None			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b COUNTY Frederick	13c CITY OR TOWN Frederick	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 514 Grant Place/21701			
14 FATHER'S NAME FIRST Thomas	MIDDLE H.	LAST Shoemaker	15. MOTHER'S MAIDEN NAME FIRST Effie	MIDDLE Jane	LAST Biser				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN Yes	16b SOCIAL SECURITY NO. W.W. II	16c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	17 INFORMANT Mr. C. Jane Shoemaker	ADDRESS 514 Grant Place					
End stage C.O.P.D.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTICED MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 1b PART 2)	20c YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20d YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN			COUNTY	STATE		
22a I certify that (I) <u> </u> attended the deceased from saw the deceased alive on <u>10/30</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u> </u> (did not) view the body after death.									
22b SIGNATURE <i>James S. Grissom M.D.</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 10/31/85						
22d PHYSICIAN'S NAME (TYPE OR PRINT) James S. Grissom M.D.	22e ADDRESS 1475 Taney Ave, Suite 204								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 11-2-1985	23c NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gardens	23d LOCATION CITY OR TOWN Frederick, Frederick, Md.	STATE MD					
24 FUNERAL DIRECTOR <i>R.E. Dailey & Son P.A.</i>	25a DATE REC'D. BY REGISTRAR NOV 12 1985	25b REGISTRAR'S SIGNATURE <i>John Dailey</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~sign and file~~ ~~sign and file~~ ~~sign and file~~. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other significant condition contributing to death, the medical examiner may be notified by the physician.

200812



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the two top corners. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

311131

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28/61

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Dorsey (NMN)					Sier	October	28,	1985		10:00a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		August 20, 1931		54		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
U.S.A.		U.S.A.				Frederick County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Mount Airy		5938 Yeagerstown Road				Black-top		Construction			
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Mount Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5938 Yeagertown Road/ 21771			
14. FATHER'S NAME Dorsey		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Eva Mae		MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korea 217-18-1440		17. INFORMANT Marie G. Sier, Mount Airy, Maryland 21771		ADDRESS 5938 Yeagertown Road Mount Airy, Maryland 21771		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>respiratory arrest</u>									
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>extensive sanguinous loss</u>									
		DUE TO, OR AS A CONSEQUENCE OF (c) <u>lung</u>								4 m/s	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1985</u> , to <u>Oct 25, 1985</u> . That (we) last saw the deceased alive on <u>12/25/85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We (did) (did not) view the body after death.)											
22b. SIGNATURE <u>P. Gregory Rausch</u>		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/28/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 4 West 7th St., Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Oct. 31, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Kempton Cemetery		23d. LOCATION CITY OR TOWN Kempton, Frederick, Maryland		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Smith, Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR Oct 31 1985		25b. REGISTRAR'S SIGNATURE <u>Jude L. Dunbar, Fender</u>							

18118

1921 US Survey

Land Survey

Surveyor General

Land Surveyor

Land Survey

1923 Land Survey

1924 Land Survey

Land Survey

Land Survey

Land Survey

Land Survey

Land Survey



288039

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE AGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE'S DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85 28 / 62

REG. NO.

1-
FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR	
L.	C.	Smith				<input checked="" type="checkbox"/>				10/3/1985	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR	
Male	Black	3-10-43	42 yrs.			10/3/1985				1:53 A.M.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	S.C.	10. CITIZEN OF WHAT COUNTRY?	U.S.A.	11. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH			Frederick Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md			13b. COUNTY Prince George	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 144 Key Pkwy			21701		
14 FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			Dorothy Rabb			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 251-74-9559			17 INFORMANT Sister, Jessie L. Morrison	ADDRESS 144 Key Parkway, Frederick, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Margarita A. Korell</i> M.D. Assistant MEDICAL EXAMINER											DATE SIGNED 10/3/85
EXAMINER'S NAME (TYPE OR PRINT)			111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10-8-85			23c. NAME OF CEMETERY OR CREMATORY Philippi Cmty Cm			23d. LOCATION CITY/TOWNSHIP Sandy Spring		
24. FUNERAL DIRECTOR NAME			ADDRESS Vernon Williams 4804 Ma. Ave. N.W. D.C.			25a. DATE REC'D. BY REGISTRAR OCT 10 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Bordere		
DHMH - 17 (VR A15 ME (5))											

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AMERICAN
CIVIL WAR

295090

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28/63

REG. NO.

1 - FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

LAURA ELIZABETH STALEY

LAST

MIDDLE

FIRST

3. SEX

Female

4. RACE

White

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

10. CITY OR TOWN OF DEATH

Mt. Airy

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

14319 Unionville Rd.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Md.13b. COUNTY
Fred.13c. CITY OR TOWN
Mt. Airy

14. FATHER'S NAME

ELMER

MIDDLE
E.LAST
SHAVER16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

24-46-9627

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 min

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) CHF

DUE TO, OR AS A CONSEQUENCE OF

(c) ASCVD

3 mo

20 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY?

YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on 8/8/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated

above. We (did) did not view the body after death.

22b. SIGNATURE

22c. DEGREE

ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN

22d. DATE SIGNED

10/10/85

22e. ADDRESS

109 Union St. Union Bridge MD. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPEC #)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION
CITY OR TOWN COUNTY STATE

Burial Oct. 12, 1985 Reformed Cemetery Middletown Fred. Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

Thompson Funeral Home Middletown, Md. OCT. 18 1985

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial record. Then please return carbon copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

15
35
BP
DHMH - 16 50M 4/83
(VRA 15, 4)

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YATE HUMSLEY 42041

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 2 8 / 6 4				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Sister Rose Tully						Oct. 23 1985			8:05P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS				
Female		White		Dec. 27, 1905			79 0			MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Maryland		U.S.A.					Frederick County			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Emmitsburg		Villa St. Michael, Emmitsburg, Md.								Nurse		Dgtrs. of Chari		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STREET ADDRESS				
13a. STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Emmitsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			333 S. Seton Avenue 21727					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Philip E. Tully			Rose Ware											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			264-98-4184			Sr. Josephine-Villa St. Michael, Emmitsburg								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) coronary thrombosis														
DUE TO, OR AS A CONSEQUENCE OF (b) A sepsis														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1977 19 to 10/23/85 T9, that (2) (we) last saw the deceased alive on 9/23/85 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22c. DATE SIGNED				
22b. SIGNATURE George L. Morningstar, M.D.										22c. DATE SIGNED 23 Oct. 85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS S. Seton Ave., Emmitsburg, MD 21727											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 25 Oct. 85			23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's			23d. LOCATION CITY OR TOWN Emmitsburg, Frederick, MD					
24. FUNERAL DIRECTOR NAME Skiles Funeral Home, Emmitsburg, MD 21727			25a. DATE REC'D. BY REGISTRAR'S REG. # REC'D. SIGNATURE John J. Skiles											
ADDRESS														

611206

4



AMERICAN LIBRARY

AMERICAN LIBRARY

281049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the Burial/Transit Permit. Then please remove carbon copy (page 3) and 2b should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, air other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28165

REG. NO.

1. -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE Frederick	LAST Vogt	2a. DATE OF DEATH MONTH 10	DAY 1	YEAR 85	2b. HOUR P 2:30 M	
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH 5	DAY 26	YEAR 00	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick			
10. CITY OR TOWN OF DEATH Middletown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5355 Carroll Boyer Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) main maintenance			12b. KIND OF BUSINESS OR INDUSTRY school	
13a. STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21769 5355 Carroll Boyer Rd.	
14. FATHER'S NAME FIRST unknown			15. MOTHER'S MAIDEN NAME FIRST Anna						LAST Nagel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none			17. INFORMANT 5355 Carroll Boyer Rd. Anna E. Hesson Middletown, MD				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>overexposure</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>long term</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>9-3-</u> , 19 <u>85</u> , to <u>9-30</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9-19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Bader</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Knsay BARAKAT			22e. ADDRESS 735 Park Avenue							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/4/85			23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cem.			23d. LOCATION CITY OR TOWN Baltimore	
24. FUNERAL DIRECTOR NAME D. D. Harber						25a. DATE REC'D. BY REGISTRAR OCT 4 1985			25b. REGISTRAR'S SIGNATURE Anne Carson Bader	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Minnie H. Volkman</i>						<i>10-5-85</i>				<i>12:28AM</i>	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS					
<i>F</i>		<i>WHITE</i>	<i>OCT. 10, 1890</i>			<i>94</i> YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK CO.					
VIRGINIA		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
FREDERICK		HOMewood RETIREMENT HOME			DIRECTOR			MUSIC			
13a. STATE D.C.						13b. COUNTY NONE		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
										13e. STREET ADDRESS 3145 BEACH ST. N.W. 20015	
14. FATHER'S NAME FIRST ADOLPH MIDDLE VOLKMANN LAST						15. MOTHER'S MAIDEN NAME FIRST HENRIETTA MIDDLE UNKNOWN LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
NO			578-05-3487			MR. FRANK O. ROHLAND			(SAME AS ITEM #13)		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>48 Hours</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20b. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED		ENTER NATURE OF INJURY (ITEM 18, PART 1 OR PART 2)				
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			22c. LOCATION CITY OR TOWN		CITY OR TOWN			COUNTY STATE	
22d. I certify that (I) (We) intended the deceased to live now, the deceased died on <i>10-5-85</i> at <i>11:54 AM</i> and that (I) (We) did not view the body after death.					19		10-5-85			that (I) (We)	
22e. SIGNATURE <i>Robert L. Kaufman, MD</i>		22f. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED <i>10-5-85</i>				
22h. PHYSICIAN'S NAME (TYPE OR PRINT)		22i. ADDRESS									
<i>ROBERT L. KAUFMAN MD.</i>		<i>804 Toll House Ave FREDERICK, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 10-5-1985		23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN RIVERDALE		COUNTY P.G.C.		STATE Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS SILVER SPRING, Md.		25a. DATE REC'D. BY REGISTRAR OCT 9 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidon Pendee</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be used for use as the burial/transit permit. Then please remove carbon copies. Please return this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be called to witness the death.

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DHMH - 16 SOM 1/81
(VRA 15, 4)



297009

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8528761

REG. NO.

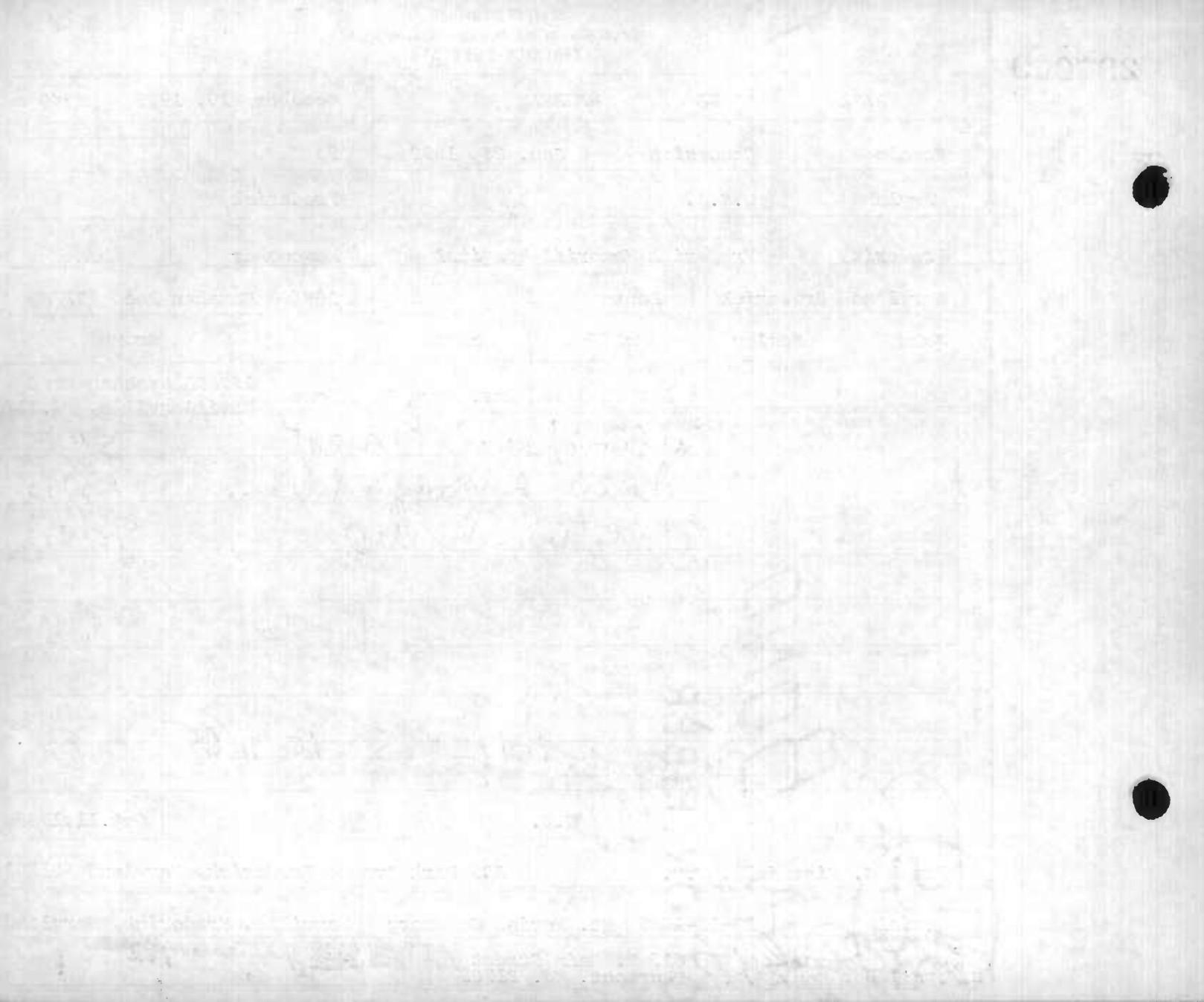
1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
				ALTA	MABEL	WAGAMAN	October		10,	1985	9:40 a.m.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS		
Female		Caucasian		Month Day Year Jan. 24, 1892		93		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.				Frederick,						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Memorial Hospital					Homemaker		None			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS		MD.		
Maryland		Frederick		Lantz				15959A Manahan Road		21780		
14 FATHER'S NAME		FIRST	MIDDLE	15 MOTHER'S MAIDEN NAME								
		John	Wesley	Hannah								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS						
No		162-22-0828		Mrs. Mary Jane Long		15959A Manahan Road Sabillasville, Md. 21780						
18 CAUSE OF DEATH Enter only one cause per line for item (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardsclerosis Arrest</i> Acute pulmonary embolism 7 days												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Froctional hip</i> 9 days												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a I certify that (1) this hospital attended the deceased from <u>10/11/85</u> to <u>10/11/85</u> , 1985, to <u>10/11/85</u> , 1985, that (1) we lost spouse, the deceased alive on <u>10/11/85</u> , 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) did not view the body after death.												
22b SIGNATURE		22c DEGREE		22d DATE SIGNED								
<i>Frank G. Nisenfeld</i>		M.D.		Oct. 11, 1985								
22e PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
Frank G. Nisenfeld, M.D.												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		10-13-1985		Mt. Moriah Cemetery		Foxville, Frederick, Maryland						
24 FUNERAL DIRECTOR <i>R.E. Daffey & Son, P.A.</i>		615 ^{100th} Main Street Thurmont, Md. 21788		25 DATE RECEIVED BY REGISTRAR <i>Oct. 11, 1985</i>		26 REGISTRATION NUMBER <i>100-111-1111</i>						
BP _____												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please attach to the death papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



289164

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

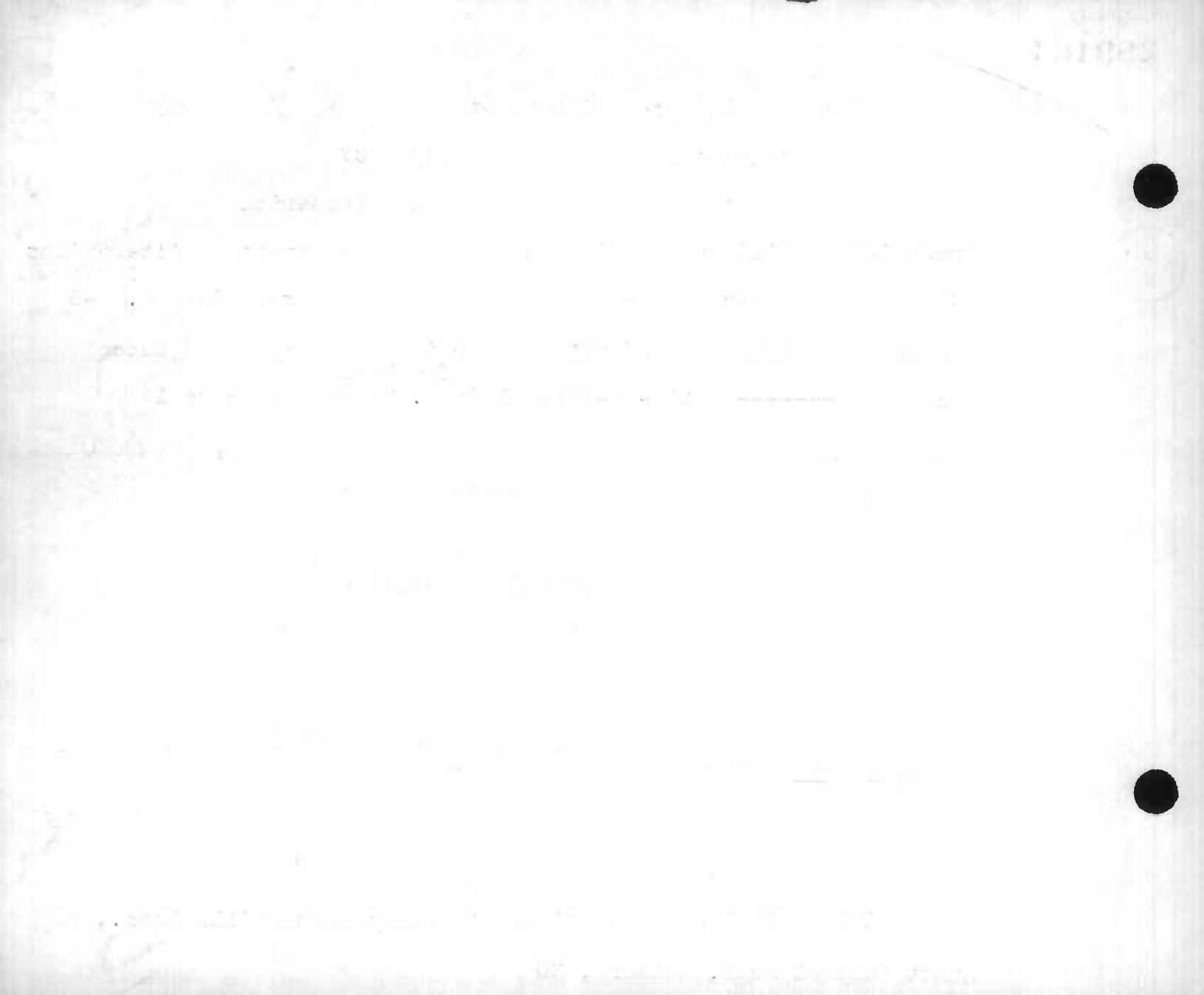
1. DECEASED NAME Lillian Padgett Warfield			2d. DATE OF DEATH Oct. 8 1985	2e. MONTH Oct.	2f. DAY 8	2g. YEAR 1985	2h. HOUR 730P
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH May 15 1898	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.				
10. CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Alterations		
13a. STATE MD	13b. COUNTY Frederick	13c. CITY OR TOWN Germantown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 20400 Frederick Rd. J-6		20874	
14. FATHER'S NAME FIRST John	MIDDLE Wesley	LAST Padgett	15. MOTHER'S MAIDEN NAME FIRST Rosie	MIDDLE May	LAST Lucas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 216-07-5435	17. INFORMANT daughter	ADDRESS Elsie M. Wishon same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour.				
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arterio-Sclerosis			15 years				
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Lymphatic Leukemia							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 26 1985 to Oct. 8 1985 , that (I) (was) lost saw the deceased alive on Oct. 8 1985 , and that in (my) (was) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard O. Thomas Jr.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Oct. 8, 1985				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bernard O. Thomas Sr.	22e. ADDRESS 228 N. Market St. Frederick, Md. 21701						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/12/85	23c. NAME OF CEMETERY OR CREMATORIAL Old Fields Cemetery Hughesville Chas.	23d. LOCATION CITY OR TOWN Hughesville Chas.	STATE MD			
24 FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD	ADDRESS	25a. DATE REC'D. BY REGISTRAR OCT 14 1985	25b. REGISTRAR'S SIGNATURE Pendleton				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3.100



297075

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 69

1 - STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST: Charles	MIDDLE: N. M. N.	LAST: WARNER, Jr.	2a. DATE OF DEATH	MONTH: 10	DAY: 18	YEAR: 1985	2b. HOUR: 335 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. TIME	
Male		Negro		MONTH: 3	DAY: 17	YEAR: 04	8. AGE (IN YEARS LAST BIRTHDAY)	9. UNDER 1 YEAR	10. UNDER 24 HRS	11. MONTHS SINCE	12. HOURS AND MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. KIND OF BUSINESS OR INDUSTRY	
Maryland		US		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Frederick			MD	
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Frederick		Frederick Mem. Hosp					Farm Hand				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		135 E. 3rd St. 21701			
14. FATHER'S NAME		FIRST: Charles	MIDDLE: Warner	LAST:	15. MOTHER'S MAIDEN NAME		FIRST: Laura	MIDDLE: Virginia	LAST: Matthews		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH					
No		218-12-7934		Annabelle Jones,		1120 Shaffersville Rd.		Mt. Airy, Md. 21771			
19. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Renal Failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Liver failure, Congestive heart failure, S/p Surgery</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT A MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
22a. INJURY OCCURRED HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
23a. I certify that (if in hospital) attended the deceased from saw the deceased alive on 10-17 1985 to 10-18 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, we did not view the body after death.		23b. SIGNATURE		23c. DEGREE		23d. ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	
24a. SIGNMAN'S NAME (TYPE OR PRINT) <i>Ronardo E. Miller</i>		24b. ADDRESS 4 Culwell Dr., Mt. Airy, Md. 21771		24c. DATE SIGNED 10-18-85							
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		25b. DATE Oct. 21, 1985		25c. NAME OF CEMETERY OR CREMATORIUM Simpson Chapel		25d. LOCATION CITY OR TOWN Poplar Springs, Howard, Md.		COUNTY		STATE	
25e. DATE REC'D. BY REGISTRAR OCT 22 1985		25f. REGISTRAR'S SIGNATURE <i>Sylvia Davidson Pendleton</i>									
BP											
DHMH - 16 60M 7-B4 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked, or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

291007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 28 / 70

1 - STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Laura	E.	West		10	14	85		12:46 P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Female	White	MONTH	DAY	YEAR	82	YRS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.					Frederick			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Frederick	5224 Jefferson Pike, Fred. Md.					Housewife			Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland	Frederick	Frederick						5224 Jefferson Pike 21701	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS	
Raymond	Otis	Young	Nora			Elizabeth	Fogle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No	219-36-4237			Davie West 5234 Jefferson Pike Fred.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic bronchitis and emphysema</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>congestive Heart Failure</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> 19 <u>85</u> to <u>Oct.</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Oct.</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Boyle</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-15-85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kunay Barakat</u>		22e. ADDRESS <u>375 Park Avenue, Frederick MD 21701</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <u>10-17-85</u>	23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		Union Chapel Ceme.			Libertytown Fred. Md.				
24. FUNERAL DIRECTOR G. Douglas Stauffer NAME 1621 Opossumtown Pike, Frederick, Md. 21701	ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>OCT 16 1985</u>		25b. REGISTRAR'S SIGNATURE <u>G. Douglas Stauffer</u>			

comes

and others
also
different ways

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene either to burial, cremation, or removal. If item 18 is marked or item 21 is marked or item 22 is marked, it must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8528771		
										REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Maurice			L.	Wetzel		6	26	85	90	YRS	1:30 A.M.	
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR								
Male			White	6	26	1895	7a. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Pennsylvania			U.S.A.				9 BALTIMORE CITY OR COUNTY OF DEATH		Frederick			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Sabillasville			16131 Sabillasville Rd.			Fireman			St. of Md.			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21780	
Maryland			Frederick	Sabillasville				16131 Sabillasville Rd.				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Harvey			E.	Wetzel	Mary			E.	Hardman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			213-18-9823			Alice Eyler			16123 Sabillasville Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and 1c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (if this hospital) attended the deceased from 1970, 19, to 10/26/85, 19, that (if we) last saw the deceased alive on 3/85, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did/did not view the body after death.												
22b. SIGNATURE <i>George Morningstar MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/28/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Seton Ave. Emmitsburg Md. 21724						
George Morningstar												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial			10-29-85		Friends Creek Cem.			Sabillasville Fred. Md.				
24. FUNERAL DIRECTOR NAME			G. Dougals Stauffer ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
1621 Opossumtown Pk. Fred. Md.						10/28/85			<i>John D. Anderson</i>			

294107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 3 should be detached for use as the burial transit permit. Then please remove entire signature from page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

BP _____

DHHM - 16 60M 7/84
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
DEAN CLARK WILDER						October 6, 1985				7:19 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
Male		White		Sept. 1, 1901		84							
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
New Hampshire		U.S.A.				Frederick							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Memorial Hospital		Newspaper Editor		Printing							
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13a. STATE N/A		13b. COUNTY N/A		13c. CITY OR TOWN Washington, DC		13e. STREET ADDRESS / ZIP CODE 500 23rd Street, N.W. 20032							
14. FATHER'S NAME FIRST MIDDLE LAST		Richard E. Wilder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. ADDRESS 143 D Street, S.E. Washington, D.C. 20003							
Yes		WWII		16b. SOCIAL SECURITY NO 063-09-6732		17. INFORMANT Dean Wilder (Son)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Respiratory Arrest							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last						(b) Sepsis							
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION N.R.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 2, 1985, to Oct 6, 1985, that (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on Oct 5, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Michael Gehre		22c. DATE SIGNED 10/14/85		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Gehre		22e. ADDRESS Frederick, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/8/85		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory		23d. LOCATION CITY/TOWN Alexandria		COUNTY		STATE Virginia			
24. FUNERAL DIRECTOR NAME Money & King Vienna Funeral Home ADDRESS 171 W. Maple Ave. Vienna, VA 22180						25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE John Doe					

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